REPORT RESUMES

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MEDICAL RECORD TECHNOLOGY, A COURSE OF STUDY DESIGNED FOR COOPERATIVE PART-TIME STUDENTS EMPLOYED IN MEDICAL RECORD LIBRARIES.

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DESIGNED FOR USE BY ELEVENTH GRADE COOPERATIVE PART-TIME STUDENTS EMPLOYED IN MEDICAL RECORD LIBRARIES, THIS GUIDE MAY ALSO BE USED IN AREA VOCATIONAL OR POST-HIGH SCHOOL SETTINGS. IT WAS DEVELOPED BY A CONSULTANT COMMITTEE, TEACHER EDUCATORS, AND RESEARCH ASSISTANTS AT THE STATE LEVEL AND REVISED AFTER USE IN THE FIELD. THE CONTENT OBJECTIVES ARE FOR STUDENT MASTERY OF JOB SKILLS AND PROCEDURES, COMPREHENSION OF INFORMATION BASIC TO THE OCCUPATION, AND DEVELOPMENT OF ESSENTIAL PERSONAL-SOCIAL TRAITS. ASSIGNMENT SHEETS PROVIDE BASIC INFORMATION, RELATED READINGS, EXERCISES RELATED TO THE WORK SITUATION, AND OBJECTIVE-TYPE TESTS FOR THE AREAS (1) THE MEDICAL RECORD LIBRARIAN AND TECHNICIAN, (2) VALUES AND USES OF THE MEDICAL RECORD, (3) BASIC AND SPECIAL MEDICAL RECORDS, (4) RESPONSIBILITY IN RECORD PREPARATION, (5) MEDICAL TERMINOLOGY, (6) FILMING AND FILING PROCEDURES, (7) DISEASE AND OPERATION NOMENCLATURE, (8) INDEXING PROCEDURES, (9) THE "INTERNATIONAL CLASSIFICATION OF DISEASES" AND DATA PROCESSING PROCEDURES, (10) STATISTICAL DATA, (11) LEGAL ASPECTS, (12) INTERDEPARTMENTAL RELATIONS, AND (14) INTRADEPARTMENTAL ORGANIZATION. AN ANALYSIS OF MEDICAL RECORD TECHNOLOGY AND PROGRESS RECORDS TO BE COMPLETED BY THE EMPLOYER, TEACHER, AND STUDENT ARE INCLUDED. THE MATERIAL SHOULD BE USED WITH RELATED INSTRUCTION FOR INDIVIDUAL STUDENTS BY A QUALIFIED COORDINATOR OR COMPETENT HEALTH OCCUPATIONS TEACHER. THE TIME ALLOTMENT IS 180 DAYS. THIS DOCUMENT IS AVAILABLE FOR $1.50 FROM INDUSTRIAL EDUCATION, 103 INDUSTRIAL EDUCATION BUILDING, UNIVERSITY OF MISSOURI, COLUMBIA, MISSOURI 65201. (JK)

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MEDICAL RECORD TECHNOLOGY

A Course of Study

**Designed for
Cooperative Part-time Students
Employed in Medical Record Libraries**

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MEDICAL RECORD TECHNOLOGY, cooperatively with Industrial Education

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REFERENCE FOR MEDICAL RECORD TECHNOLOGY

1. Huffman, Edna K., Manual for Medical Record Librarians, Fifth Edition, Physicians' Record Company, 3000 South Ridgeland Avenue, Berwyn, Illinois, 60402, 1963, $10.00.* (17) **

* Subject to educational discount
** Frequency of use in assignments

FOREWORD

This course of study, consisting of an analysis of MEDICAL RECORD TECHNOLOGY, together with assignment sheets covering the related (occupational) information to be taught by the school, has been prepared for teaching medical record technicians on an individual basis in a cooperative part-time program.

The original analysis and assignment sheets were prepared by Dr. Carl R. Bartel and Dr. Harlan L. Scherer, formerly Research Assistants in Industrial Education at the University of Missouri. The present revision of the analysis and the assignment sheets was prepared by Mr. Donald E. Maurer, Research Assistant in Industrial Education at the University of Missouri.

We wish to acknowledge our indebtedness to Dr. H. H. London, Professor of Industrial Education at the University of Missouri, for the direction and administration of the Curriculum Materials Laboratory in which this material was prepared, and to Mr. James B. Karnes, Instructor in Industrial Education at the University of Missouri, who supervised the preparation of the material and edited the manuscript. Credit is due to Mr. B. W. Robinson, Assistant Commissioner of Education, Mr. Merton Wheeler, Director of Industrial Education, and to other staff members of the State Department of Education for their efforts in the development of the Industrial Education Curriculum Series of which this course of study is a part.

HUBERT WHEELER

Commissioner of Education

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Training Plan and Progress Record

INTRODUCTION

In preparing this course of study, it has been assumed that the attainment of occupational competency in any type of work involves three different, yet closely related, types of learning. They are:

1. Mastery of the practical job skills and procedures performed by the worker in the occupation.

2. Comprehension of the technical and related information basic to an intelligent understanding and practice of the occupation.

3. Development of those personal-social traits which are essential for the successful worker.

The first group of these "learning units"--the job skills and procedures--has been arranged in the analysis under the heading of "Job Training." The second group of learning units--the technical and related information--has been arranged under the heading of "Related Information." And the third group--the personal-social traits--has been listed under "Personal-Social Traits Essential for the Medical Record Technician" in the introductory section addressed to the student.

In a cooperative educational program it is necessary for both cooperating agencies--the school and the employer--to understand clearly just what each is to be responsible for in the training of the student-worker. Experience has shown that most of the practical job skills and procedures of an occupation can best be learned through supervised work on the job. Experience has shown also that the school can best teach most of the technical and related occupational information needed by young student-workers. This division of responsibility has been made in the arrangement of the course of study; that is, it is expected that the student-worker will master the job skills and procedures through practical work on the job under the immediate supervision of the employer, and that he will receive instruction in related occupational information in the school under the direction of the coordinator.

Skills and related information are matters for direct instruction, but personal-social traits are acquired only through practicing them during the process of acquiring skills and information and in one's daily conduct. Therefore, both the employer and the school, as well as the home, must assume responsibility for developing in the student-worker those habits, attitudes and character traits which are essential for success in his occupation and in life. Both the employer and the school should be constantly on the alert to see that the student-worker places desirable interpretations on his experiences and that he does not practice habits and exhibit character traits detrimental to his success.

Since the coordinator's class will be made up of fifteen or more students, each differing from the other significantly, studying a dozen or more occupations which differ markedly in their requirements, it follows that it will be impossible for him to teach, through the group method, the occupational information which relates to the specific job of each student-worker. In order to be effective, this type of instruction must be individualized. There is, of course, some related information, such as occupational health and safety, workmen's compensation, wage-hour laws, fair labor standards, unemployment compensation, and the like, which is of common interest and concern to all student-workers, and may be effectively taught by the group method. But if the coordinator is to make a real contribution to the in-service vocational education of his students, he must devote a major portion of his classroom instruction to content which deals specifically with the work of each boy and girl enrolled.

With this requirement in mind, and in order to facilitate individual instruction, these assignment sheets have been prepared. Each contains certain record data as to number and range of units covered, introductory paragraphs designed to develop interest, explain the importance of the assignment, and to convey to the student what he is expected to learn, specific assignments including reading, learning activities and a series of new-type questions designed to check his attainment.

Obviously, it is desirable to teach the related information in the school at the time it will be used most advantageously on the job. This means that the two phases of the student-worker's training should parallel each other in a progressive manner. The coordinator will find the assignment sheets well adapted to this end. He can select from day to day the assignment which covers the informational units related to the work being done on the job. With this arrangement, the coordinator will become, during a major portion of his classroom time, a supervising study and helping teacher.

In selecting books for the course, an effort has been made to restrict the number to an adequate coverage of the material, and to select those of recent publication so that current practices can be consistently presented. It is recommended that copies of these books be secured and kept in the coordinator's classroom for ready use by the student.

The key sheets, available in a separate manual, have been prepared to enable the coordinator to score quickly the objective tests which are a part of each assignment sheet. These key sheets give the correct answers to the questions, as well as the reference' and the page on which each answer can be found. The key sheets should be kept in the coordinator's possession.

TO THE STUDENT-WORKER

Within the past decade the increased responsibilities placed upon the medical record department have led to a division of personnel within the medical record department. Formerly, about all that was essential for the efficient operation of the medical record department was a qualified medical record librarian. Today he is aided by various personnel in his department, e.g., the medical record technician.

The medical record technician works under the supervision of the medical record librarian in large hospitals. In smaller hospitals the medical record technician may work under the medical record committee or a medical record group supervisor. The work of the medical record technician consists of the technical tasks associated with the maintenance and custody of medical records. However, he is not trained to exercise professional judgment.

Opportunities for Medical Record Technicians

The medical record technician is employed not only in hospitals but also in medical departments of industrial organizations, in health departments, health agencies, Blue Cross and Blue Shield organizations, commercial insurance companies, clinics, and in many other organizations. There is a great opportunity for advancement in this field today. A high school graduate can attend an approved school for medical record technicians, and upon completion write an examination for accreditation. While working as an accredited medical record technician, he can prepare himself for further advancement by accumulating sixty hours of college or university credit; this is one of the requirements for a registered medical record librarian. The future of the medical record technician appears exceedingly bright and opportunity is only limited by the individual's sincerity, ambition, and willingness to work.

Personal Qualifications of the Medical Record Technician

To aid the beginning student in the field of medical record technology a copy of The Birtcher Word Book, courtesy of the Birtcher Corporation, has been included with this course of study. This little booklet will prove to be a valuable asset for the understanding of medical and surgical terminology. A period of nine months' training in an approved school and the successful completion of an accreditation examination are necessary to qualify as an accredited medical record technician.

Among the personal-social traits of chief importance to the medical record technician are the following:

Health--Observe habits that promote vitality and vigor.

Persistency--It is essential that the medical record technician develop the patience and perseverance to see his task through to completion.

Accuracy--A vital trait necessary for the technician, as accurate and complete medical records furnish the basis for analysis of hospital activities.

Cooperativeness--It is essential that the medical record technician work harmoniously with the medical staff, the patients, and other employees.

Intelligence--Average or above-average intelligence is necessary for successful performance as a medical record technician.

Progressiveness--The medical record technician must keep abreast of changing methods and constantly strive to improve his knowledge and experience in the medical record field.

Decisiveness--The ability to distinguish between essentials and non-essentials, to move to the heart of the problem, to tackle it and sweep trivia aside.

Initiative and Industry--The ability to see things that need to be done and to keep busy without constant supervision.

Poise--The medical record technician should have satisfactory control of his emotions and carriage.

Diplomacy--The ability to deal with others and secure advantages without arousing their hostility.

Trustworthy--A highly indispensable trait necessary for the technician, as he is constantly dealing with records of a confidential nature and must not reveal their contents to unauthorized personnel.

REFERENCE FOR MEDICAL RECORD TECHNOLOGY

1. Huffman, Edna K., Manual for Medical Record Librarians, Fifth Edition, Physicians' Record Company, 3000 South Ridgeland Avenue, Berwyn, Illinois, 60402, 1963, $10.00.* (17) **

* Subject to educational discount
** Frequency of use in assignments

ANALYSIS OF MEDICAL RECORD TECHNOLOGY

JOB TRAINING: What The Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
Duties, Functions and Opportunities		
	1	1. Introduction to the medical record librarian and technician
	1	2. Professional ethics
	1	3. Educational and personal qualifications
	1	4. Responsibilities and duties
Value and Use of Medical Records		
5. Assemble the medical record	2	5. Major sections of the medical record
	2	6. Uses of the medical record
	2	7. Value of the medical record
Basic Medical Records		
8. Check summary sheet	3	8. Content of summary sheets
9. Check admission or social history record		
10. Check history records	3	10. Types of history records
11. Check physical examination records	3	11. Content of physical examination reports
12. Check laboratory reports	3	12. Types of laboratory tests and their use
13. Check physician's orders	3	13. Types of physician's orders

JOB TRAINING: What The Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
14. Check graphic chart	3	14. Origin and content of graphic charts
15. Check nurses' bedside record		
	3	16. Errors of omission or commission
Special Medical Records		
17. Check consultation report	4	17. Rules and regulations pertaining to consultation records
18. Check anesthesia record	4	18. Contents of anesthesia records
19. Check report of operation	4	19. Rules and regulations pertaining to operation reports
20. Check tissue and recovery room report	4	20. Content of tissue and recovery room report
21. Check electrocardiographic and x-ray report	4	21. Content of electrocardiographic and x-ray report
22. Check obstetrical records	5	22. Types of obstetrical records and their use
23. Check newborn records	5	23. Types of newborn records and their use
	5	24. Obstetrical terms and definitions
25. Check miscellaneous	5	25. Types and uses of miscellaneous records
	5	26. Deficiency records and their use

JOB TRAINING: What The Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
Responsibility in Medical Record Preparation		
	6	27. Attending physician's responsibility
	6	28. Responsibility of the medical staff
29. Assist physicians making reports of operations	6	29. Contents of operative reports
	6	30. Purposes of nurses' records
	6	31. Terminology of bedside records
	6	32. Factors to be charted and manner of charting
	6	33. Order of assembling nurses' records
	6	34. Types and uses of medical dictation systems
Medical Terminology		
	7.	35. Basic stems of Latin and Greek medical terms
36. Spell and pronounce medical terms correctly		
	7	37. Prefixes of medical terms and their meanings
	7	38. Suffixes of medical terms and their meanings
39. Follow directions given in medical phraseology		
	7	40. Singular and plural noun formations
	7	41. Homonyms and other terms easily confused

JOB TRAINING: What the Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
	7	42. Types of eponyms and their meanings.
43. Record in medical and surgical terms		
	8	44. Common disease terms
	8	45. Terms used in anesthesiology
	8	46. Drug terms
	8	47. Standard abbreviations and others sanctioned by use
	8	48. Hospital terms
	8	49. Departmental or service classification terms

Filming and Filing Medical Records

	9	50. Types of serial numbering systems
	9	51. Unit numbering systems
52. File records	9	52. Types of decentralized filing systems
	9	53. Types of centralized filing systems
	9	54. Terminal digit filing systems
55. Prevent misfiles		
56. Locate misfiles		
57. Prepare records for microfilming	9	57. Filing unit records
	9	58. Advantages and disadvantages of microfilming

Nomenclature of Diseases and Operations

	10	59. Systems of classification

JOB TRAINING: What the Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
60. Code diseases	10	60. Nomenclature of diseases
	10	61. Decimal digits and their uses in classifying
	10	62. Nomenclature of operations
63. Code operations	10	63. Behavior or malignancy code letters
	10	64. Disease and operation indexes
Indexing Procedures		
65. Compile patients', physicians', disease, and operation records	11	65. Types of indexes
66. Index records using the dual group method	11	66. Methods of indexing and filing records
67. Index records using the simple index method		
68. Index records using the master code number method.		
69. Index records using the alphabetical sequence method		
70. Index records using the phonetic sequence method		
71. Cross-index diseases and operations	11	71. Techniques for cross-indexing diseases and operations
72. Select and use file cards, guides, and file equipment	11	72. Types of filing equipment
International Classification of Diseases		
	12	73. History and purpose of the *International Classification of Diseases*

JOB TRAINING: What The Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
74. Index records using the I C D	12	74. Techniques and procedures for using the I C D
75. Index records using the I C D A	12	75. Techniques and procedures for using the International Classification of Diseases, Adapted
Automatic Data Processing		
	12	76. Terminology used in the automatic processing of data
	12	77. History, purpose and systems of automatic data processing
78. Process medical data automatically	12	78. Techniques in the automatic processing of medical data
Statistical Data		
79. Collect registration data	13	79. Birth and death certificates
80. Determine basic data	13	80. Statistical classification of records
	13	81. Analyzing hospital service
82. Prepare daily hospital census		
83. Prepare daily discharge analysis	13	83. Discharge analysis procedure
Statistical Data and Reports		
84. Compile monthly and annula statistical reports	14	84. Types of statistical reports
85. Compute percentages and rates	14	85. Rates most frequently computed
86. Prepare statistical reports		
87. Tabulate data for reasearch		
	14	88. Rates computed from the census

JOB TRAINING: What the Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
Legal Aspects of Medical Records		
89. Handle requests for information	15	89. Property right and privileged communication
	15	90. Releasing information from the medical record
91. Present medical record in court	15	91. Types of cases requiring evidence from medical records
	15	92. Hospital lien laws
	15	93. Court interpretations of medical records
Interdepartmental Relations		
94. Orient new employeee	16	94. Desirable personal qualities for successful contacts with people
95. Instruct new employees		
	16	96. Responsibilities of various hospital departments
97. Check work of employees		
98. Mark books	16	98. Classifying medical reference material
99. Make card catalog cards		
	16	100. Basic medical library list
	16	101. Inter-library loans
102. Make shelf list		
Organization, Management and Supervision of the Medical Record Department		
103. Make an organization chart	17	103. Types of organization

JOB TRAINING: What the Worker Should Be Able To Do	Assign. No.	RELATED INFORMATION: What The Worker Should Know
	17	104. Making a job analysis
	17	105. Determining work flow
	17	106. Types of internal controls
	17	107. Planning a medical record department
108. Estimate personnel and equipment needs		
	17	109. Planning a file room
110. Select record forms	17	110. Quality of record forms

Assignment
Sheet No. 1

Covering
Units 1-4

THE MEDICAL RECORD LIBRARIAN AND TECHNICIAN

The development of medical records somewhat parallels the growth and development of medicine. The greatest improvement occurred with the hospital standardization movement in 1918, and further growth was experienced after the extablishment of training programs for medical record technicians and librarians in the 1930's to the present time.

The profession of the medical record librarian and technician is essentially a woman's occupation since they generally have the required aptitude, and also can adapt themselves well to the varying situations of the job. A great opportunity now exists in this field, and one is limited only by one's own ability and initiative. The work of the medical record librarian and technicians is exacting and highly confidential and, therefore, demands someone willing to devote her life to the work and one who is completely trustworthy.

In this assignment you will have an opportunity to learn the place, functions and opportunities of the field of the medical record librarian and technician.

Assignment:

1. Read the given reference listed below.
2. Become familiar with the various job opportunities in the field of medical record work by talking to those in that work and by further reading on the subject. Write a short paper of 500 words or less presenting the information which you found on job opportunitess.
3. Answer the questions below and turn in this assignment by ________________________.

References:

A. Huffman, Manual for Medical Record Librarians, pp. 133-158

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The only use of a medical record is as a tool in the care of a patient.

T F 2. If discrepancies are discovered in a medical record, they should be corrected by the medical record librarian or she should have them corrected.

T F 3. Ethics and etiquette are synonymous terms when used by the medical records personnel.

T F 4. The pledge of ethics of the American Association of Medical Record Librarians is quite similar to the Oath of Hippocrates.

T F 5. Laws have been enacted for the prevention of the misuse of information contained in medical records.

T F 6. Information that a patient is unable to obtain from the physician should always be given to the patient by the record librarian or technician.

T F 7. A medical record librarian must be qualified to work in hospitals of various sizes and types.

T F 8. The medical record librarian should have a thorough knowledge of the Standard Nomenclature of Diseases and Operations.

T F 9. One of the duties of a medical record librarian and technician is the providing of medical record data for studies and research carried on by physicians.

T F 10. It is essential that a medical record technician have some secretarial training.

T F 11. The terms "medical record librarian" and "medical reference librarian" are used interchangeably in hospitals.

T F 12. It is not necessary for a medical record librarian to understand what a diagnosis means.

T F 13. Membership in the American Association of Medical Record Librarians means that the person is a registered medical record librarian.

T F 14 It is entirely correct to refer to any of the personnel working in the medical records department as "medical record librarian."

T F 15. A trained medical record technician is one that has the ability to exercise professional judgment on matters concerning medical records.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. An administrative medical record librarian must be a ______________ and be able to ______________ ______________.

2. The oath upon which all medical ethics is based on is the Oath of ______________.

3. The medical record librarian and technician is in a position of great trust and, therefore, must always be honest, ______________ and loyal.

4. After a medical record librarian successfully passes a written examination, she receives a Certificate of ______________.

5. A stenographer in the medical record department must have a good knowledge of ______________ and ______________ terminology.

6. A board that was recognized in 1932 and which has set up a standard of qualifications for medical record librarians is the Board of ______________.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. A medical record librarian and technician come in contact with many people and associate daily with:

   (A) ______________________________

   (B) ______________________________

   (C) ______________________________

   (D) ______________________________

   (E) ______________________________

   (F) ______________________________

   (G) ______________________________

   (H) ______________________________

2. The personal qualifications needed by a medical record librarian and technician are:

(A) ____________________

(B) ____________________

(C) ____________________

(D) ____________________

(E) ____________________

(F) ____________________

(G) ____________________

(H) ____________________

(I) ____________________

(J) ____________________

3. List the grades of medical record personnel found in many of the large hospitals which are discussed in detail in your text book:

(A) ____

(B) ____

(C) ____

(D) ____

(E) ____

(F) ____

4. A medical record technician, who is accredited, is qualified to work under the supervision of:

(A) ____

(B) ____

(C) ____

5. Medical record librarians are not only employed in hospitals, but also in the following types of organizations:

(A) ____

(B) ____

(C) ____

(D) ____

(E) ____

(F) ____

(G) ____

Assignment
Sheet No. 2

Covering
Units 5-7

THE MEDICAL RECORD: VALUES AND USES

Records of one kind or another have always been kept in hospitals. These have been improved until today much valuable information may be gained from these records that will benefit the patient, physician, and others interested in the advancement of medical science.

The medical record is a story of the patient. It contains a complete history of the individual during his stay in the hospital. The medical record is a record of the progress and quality of work accomplished by the entire hospital staff, which includes the personnel of the medical record department. A great responsibility rests on the shoulders of this department for the accurate and confidential maintenance of these records.

In this assignment you will have an opportunity to learn the place of the medical record in the hospital, and its values and uses.

Assignment:

1. Read the reference listed below.
2. Become thoroughly familiar with the uses of the medical records in the hospital in which you work. From this observation write a short report regarding the major uses and discuss your findings with your coordinator or supervisor.
3. Answer the questions below and turn in this assignment by ____________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 33-39, 126-132.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The medical record contributes to and reflects the quality of professional and medical care rendered the patient.

T F 2. After a patient's record is initiated, very few additional entries or other additions are made throughout the stay of the patient.

T F 3. A major duty of the medical record librarian is to check the completeness of the medical record.

T F 4. The order for assembling the medical record is the same on the floor as for permanent filing.

T F 5. A chart indicating patients who have been discharged the previous day should be in the medical record department the following morning.

T F 6. Practically all hospitals use the same style of record forms for use in keeping patient records.

T F 7. Medical records are used, at times, in insurance and compensation cases.

T F 8. In most states, the medical record, as a personal document, is not available to insurance companies.

T F 9. A husband has a right to review the medical record of his wife without her authorization.

T F 10. Upon rehospitalization of a patient, a second attending physician cannot use the records of previous hospitalization without the authorization of the first physician.

T F 11. It is definitely justifiable to prevent a patient from securing information from his own medical record.

T F 12. If research is being carried on by a staff physician and not for publication, permission to use records from the attending physician need not be obtained.

T F 13. A medical record has legal value.

T F 14. One reason that a comprehensive record is taken of each patient is that it is impossible for the physician to remember the details of each separate case.

T F 15. An adequate and complete medical record is useful for defense in malpractice suits.

T F 16. One of the recognized inadequacies of the medical record is the fact that it does not show the times a physician has been called in for consultation.

T F 17. The medical record contains a reliable source which when used effectively will aid in the advancement of medical science.

T F 18. An informal teaching program is continually being carried on in well-operated and administered hospitals.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. To meet the criteria set up for an adequate medical record, it must be analyzed ____________________ by the medical record librarian and ____________________ by the physician.

2. Many hospitals have mechanized their medical record paper work by adopting _______________ copy forms and _______________ plates.

3. There are basic essentials that must be included in the medical record by any hospital in order to maintain _______________ standards.

4. A medical record may be used as either a _______________ or _______________ document.

5. Executors of estates are allowed to use medical records only after they present proof of their _______________.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The medical record begins in the (A) medical record department; (B) admitting department; (C) patient's room; (D) operating room.

_____ 2. Progress of a patient is recorded on the medical record by the (A) nurse; (B) medical record librarian; (C) physician; (D) clerk.

_____ 3. Many administrators feel that mechanization is (A) too costly; (B) a waste of time; (C) is beneficial to doctors but not the hospital staff; (D) a time saver and thus a money saver.

_____ 4. The medical record librarian performs his greatest service to the patient in the (A) quantitave analysis of the record; (B) technical evaluation of the record; (C) both A and B; (D) neither A or B.

_____ 5. Medical records must be safely guarded mainly because of (A) misplacement possibilities; (B) their confidential nature; (C) misuse by physicians; (D) none of these.

_____ 6. The initial qualitative analysis of the medical record is the responsibility of the (A) attending physician; (B) medical record librarian; (C) floor nurse; (D) medical audit committee.

_____ 7. Signatures of persons entering data into the medical record are required of (A) only the physician; (B) only the nurse; (C) only the record librarian; (D) all individuals who enter such information.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. The order of arrangement of the medical record for permanent filing generally follows the following order:

(A) ____________________

(B) ____________________

(C) ____________________

(D) ____________________

(E) ____________________

(F) ____________________

(G) ____________________

(H) ____________________

(I) ____________________

(J) ____________________

(K) ____________________

(L) ____________________

(M) ____________________

(N) ____________________

(O) ____________________

(P) ____________________

(Q) ____________________

2. A medical record is used as an impersonal document by the following:

(A) ____________________ (C) ____________________

(B) ____________________ (D) ____________________

(E) ____________________

3. Since patients forget and records remember, the record has value to:

(A) ______________________________ (C) ______________________________

(B) ______________________________ (D) ______________________________

Assignment
Sheet No. 3

Covering
Units 8-16

THE MEDICAL RECORD: BASIC RECORDS

The basic records that are included in the medical record are considered essential regardless of the patient case involved. It is very important that one working with the medical record have a sound knowledge and understanding of each one of these basic records and the function they serve in relation to the total medical record.

In this assignment you will have an opportunity to become familiar with the use and purpose of the various basic records.

Assignment:

1. Read the reference listed below.
2. Make a list of the records classified as basic that are used in the hospital in which you work. Write a short paragraph on each record to indicate its specific function.
3. Answer the questions below and turn in this assignment by ____________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 40-73.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. A summary sheet contains information necessary for indexing.

T F 2. The carbon copy of the summary sheet becomes a part of the medical record.

T F 3. A final diagnosis is necessary and is entered on the record before a patient is assigned to a room.

T F 4. The physician should be responsible for the scientific and mediocolegal content of the summary sheet.

T F 5. The medical record department is responsible for checking records received against the discharge list.

T F 6. A properly completed summary sheet fulfills the discharge summary requirements of the Joint Commission on Accreditation of Hospitals.

T F 7. Almost without exception, hospitals use the standardized form of the history record.

T F 8. A purpose of both the history and physical examination record is to serve as a reminder of essential factors for the busy physician.

T F 9. Information such as the health of immediate relatives should be included in the history record form.

T F 10. If an intern takes data for the history record form from a patient, his signature alone is all that is required.

T F 11. A standard physical examination form should be adopted by each hospital to fit its needs, as to maintain uniformity.

T F 12. The physical examination report provides space for describing the observations of the examiner of his findings.

T F 13. The summary of the case on a physical examination report is based on both subjective and objective findings.

T F 14. The provisional diagnosis may be determined by a process of elimination.

T F 15. It is the responsibility of the medical record technician to prepare a report on laboratory tests that have been made.

T F 16. All hospitals follow the practice of copying laboratory reports from the original onto a master sheet.

T F 17. Even if a report is incorrect, it is better than no report at all.

T F 18. The RBC examination is generally designated as routine laboratory examination.

T F 19. Progress notes provide a chronological record of a patient's progress day by day or, at times, hour by hour.

T F 20. If the service of an intern or resident is changed during the stay of a patient, the progress notes should be summarized and the new intern or resident carry them on from that point.

T F 21. Some hospitals require a summarization of the case as a final progress note.

T F 22. The issuance of verbal or telephone orders by physicians is considered good practice.

T F 23. The diet of the patient is often written in chronological order in the same column with the treatment on the physician's order form.

T F 24. An observation record is only used by nurses to record their observations of patients in absence of the physician.

T F 25. All notes by nurses who rendered the service should be initialed.

T F 26. The medical record librarian is not responsible for qualitative analysis of nurses' bedside records.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. The face sheet of a medical record is sometimes called a ______________ ______________.

2. An opinion given with incomplete knowledge on a case and recorded on the patient's record is called a ______________ or ______________ diagnosis

3. Following a final diagnosis, the primary disease as well as any ______________ or ______________ disease should be recorded.

4. If a record sent to the medical record department is found incomplete, it should be placed in the ______________ ______________ until completed.

5. The authorization for release of information may be either a separate form or on the back of the ______________ ______________.

6. The record of admission is sometimes called the ______________ ______________ record, the ______________ ______________ record, or identification sheet.

7. The ______________ sheet is the type generally used for history examination records in teaching hospitals.

8. The section of the history record for recording the complaints of the patient is the ______________ ______________ section.

9. The physical examination report is a statement of observations and findings supplemented by ______________ aids.

10. The physical examination report is signed by the ______________ physician if he makes the physical examination.

11. A tentative diagnosis made before any tests have been completed is entered under heading of ______________ on the physical examination report.

12. The chief of service, senior resident, or the ______________ physician should counter-sign the physical examination report when data have been taken by an intern.

13. Laboratory reports are made by the ______________ ______________ or ______________ who works under the supervisior of a pathologist.

14. AMA approved hospitals must furnish a ______________ ______________ containing concise, essential information regarding the patient's illness and its investigation and treatment.

15. Although hospitals differ, many give ______________ laboratory examinations to all patients admitted.

16. Specific statements written by the physician relative to the course of a disease are called ______________ ______________.

17. The record of all orders given by the physician is called the ______________ record or ______________ orders.

18. In some states the physician's ______________ number is followed by his signature on the order sheet for prescribing narcotics.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The reason some records are called basic record forms is that they are (A) used first; (B) necessary regardless of the type of case; (C) used only for minor cases; (D) very seldom used.

_____ 2. The summary sheet or face sheet does not contain the following item of information (A) final diagnosis; (B) provisional diagnosis; (C) social security number; (D) personal medical history.

_____ 3. The correct way to enter a single person's name on the medical records is (A) Smith, Miss Phyllis; (B) Phyllis Smith; (C) Miss Phyllis Smith; (D) Miss Smith, Phyllis.

_____ 4. Information at time of admission should be obtained by the (A) medical record librarian; (B) admitting clerk; (C) nurse; (D) physician.

_____ 5. Each progress note entered should be (A) initialed; (B) signed; (C) signed and dated; (D) initialed and dated.

_____ 6. The inventory of systems does not contain the following item of information (A) skin; (B) nose; (C) female, reproductive; (D) bleeding time.

_____ 7. The physical examination report does not contain the following item (A) cell count; (B) ear discharge; (C) salivary ducts of the mouth; (D) breast discharge.

_____ 8. Standard orders, which are routine house orders, must be signed by the (A) nurse; (B) attending physician; (C) resident; (D) chief of the service.

_____ 9. The nurses' bedside record is started by the (A) medical record librarian; (B) admitting clerk; (C) admitting physician; (D) admitting nurse.

_____ 10. Nurses' notes (A) may never be removed from the medical record; (B) are always destroyed immediately after the medical record is analyzed; (C) are always filed separate from the medical record; (D) may be destroyed according to the Statute of Limitations.

Matching

Directions: In the left hand column is a list of tests. The right hand column contains the uses and purposes of these tests. Match the uses and purposes to the tests by placing the letter of the use or purpose in the blank at the left of the appropriate test.

_____ 1. Ascheim-Zondek test
_____ 2. Schick test
_____ 3. agglutination test
_____ 4. Pirquet test
_____ 5. Papanicolaou test
_____ 6. Lipase test
_____ 7. Widal
_____ 8. cell count
_____ 9. uric acid test
_____ 10. Friedman-Hamburger test

A. a test on spinal fluid
B. a liver function test
C. a smear test to determine cancer
D. a test for pregnancy
E. a test for typhoid fever
F. a test for bacterial diseases
G. a test in diagnosis of gout
H. determine gastric carcinoma
I. determine susceptibility to diptheria
J. a skin test to determine tuberculosis

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. Two forms that usually include all information of an identifying nature are:

(A) ______________________________ (B) ______________________________

2. The four major sections of a history record form are:

   (A) ____________________ (C) ____________________

   (B) ____________________ (D) ____________________

3. A graphic chart usually gives the physician a quick picture record of the patient's:

   (A) ____________________ (D) ____________________

   (B) ____________________ (E) ____________________

   (C) ____________________ (F) ____________________

4. The four major vertical columns included in a nurse's bedside record are:

   (A) ____________________ (C) ____________________

   (B) ____________________ (D) ____________________

Assignment
Sheet No. 4

Covering
Units 17-21

THE MEDICAL RECORD: SPECIAL RECORD FORMS I

The medical record contains many different types of records, some of which are considered as special records and only used for particular cases. These records have a specific function and special care must be taken by the medical record personnel to see that data has been recorded properly, that the required signatures are included, and that patient identification data is correct.

In this assignment you will have an opportunity to become familiar with some of the special types of records and reports used in hospitals which are included in the medical record.

Assignment:

1. Read the reference listed below.
2. Write a short paragraph on each of four special records used most often in the hospital in which you work; give special precautions to be taken when checking for completeness of each one.
3. Answer the questions below and turn in this assignment by ____________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 73-92.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The special record form that will be used depends upon the case being treated.

T F 2. An attending physician desiring consultation indicates on what specific points he wants a consultant's opinion.

T F 3. A consultant need not record his findings since this is the responsibility of the attending physician.

T F 4. In checking the consultation report, all omissions should be filled in by the medical record personnel and presented to the consultant for his signature.

T F 5. A blood transfusion report will be found only in records of patients who have had surgery.

T F 6. The anesthesia record contains information as to the condition of the patient.

T F 7. A report of findings and procedures used by a surgeon at operation is recorded on the "Report of Operation."

T F 8. It is essential that the preoperative diagnosis be made prior to initial incision.

T F 9. An authorization for surgery is always found on the back of the summary sheet.

T F 10. A special authorization for an amputation should be used even though a general or blanket authorization was obtained when the patient was admitted.

T F 11. The attending nurse during an amputation should complete the report of operation if the surgeon has failed to do so.

T F 12. The same type of operative report is used for tonsilectomies as for major surgery in most hospitals.

T F 13. Small hospitals often send their tissue specimens to central laboratories for examination.

T F 14. The recovery room record is one form that does not become part of the patient's medical record.

T F 15. The report made by the cardiologist from the tracings of an electrocardiogram is generally not a part of the patient's medical record.

T F 16. An electrocardiographic report is a clinical interpretation and is signed by the attending physician.

T F 17. The carbon copy of the X-ray report becomes part of the patient's medical record.

T F 18. Almost all hospitals use short stay records.

T F 19. The short stay record is the responsibility of both the medical and nursing staff.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. When an opinion of another physician is desired, the attending physician writes a ______________ for consultation.

2. The blood transfusion report serves as legal protection to the ______________ and the ______________.

3. If a complete or part of an organ has been removed, a ____________ report must be included in the record.

4. A special form to record data concerning patients while in the recovery room following an operation is the ____________ ____________ report.

5. A graphic tracing of heart action is called an ____________.

6. The x-ray report (diagnosis) must be signed by the ____________ or ____________.

7. If a patient remains in a hospital for no longer than 48 hours as in the case of tonsillectomies, etc., a ____________ ____________ record is acceptable.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The reason for a physician requesting consultation is (A) to rid himself of responsibility; (B) to make a more accurate diagnosis; (C) because it is required; (D) none of the above reasons.

_____ 2. On operations for the purposes of sterilization, consultation with a qualified physician is (A) required; (B) not required; (C) often required; (D) seldom required.

_____ 3. The original tissue report becomes part of the medical record after it has been signed by the (A) surgeon; (B) pathologist; (C) nurse; (D) anesthetist.

_____ 4. Short stay records must be signed by the (A) medical librarian; (B) attending physician; (C) nurse; (D) is not signed.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. The three major sections to be filled in by the consultant on the report of consultation are:

(A) ____________ (B) ____________ (C) ____________

2. The four major areas of information that should be recorded on the blood transfusion record are:

(A) ____________ (C) ____________

(B) ____________ (D) ____________

Assignment
Sheet No. 5

Covering
Units 22-26

THE MEDICAL RECORD: SPECIAL RECORD FORMS II

Obstetrical and newborn records are considered as special record forms. Great care must be exercised in their proper use and preparation as well as their placement in the patient's medical record. These records, as other miscellaneous special records, have a specific function and should be used only for the particular case for which they are designed.

In this assignment you will have an opportunity to become familiar with various types of special records including those for use on obstetrical and newborn cases.

Assignment:

1. Read the reference listed below.
2. Obtain copies of obstetrical and newborn records from the hospital in which you are working. Become thoroughly familiar with the forms and the information required on them. Write a two-page summary on each of four selected obstetrical and newborn records; indicate what information is contained in each record when it is properly filled out.
3. Answer the questions below and turn in this assignment by ________________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 92-126.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. A prenatal record starts in the office of the obstetrician and records the condition of the patient during pregnancy.

T F 2. The patient's labor record is started upon admission to the hospital.

T F 3. The present pregnancy section of the prenatal record contains information concerning headache, dizziness, edema, bleeding, laboratory test results, and estimated date of confinement.

T F 4. The labor record contains space for information concerning the type of delivery as well as the condition of the newborn.

T F 5. The terms "point of direction" and "position" are used interchangeably.

T F 6. There are two divisions of presentations of the newborn.

T F 7. Various footling presentations are classified as breech presentations.

T F 8. In a brow presentation, the brow is the point of direction.

T F 9. There are four to five recognized stages of labor.

T F 10. Summary sheets or face sheets used for the newborn are the same as ones used for adult patients.

T F 11. The history of newborn delivery should provide space for information regarding the duration of labor as well as type of delivery.

T F 12. Since information concerning the delivery is on the mother's record, it is not necessary to include it on the infant's records.

T F 13. The records made on an infant become part of the medical record for later use when an adult.

T F 14. Information such as condition of the navel, skin and eyes of the infant should be recorded on the nurse's record of infant.

T F 15. It is an accepted practice to make out an accident report on only serious injuries.

T F 16. Each accident case should be considered as a potential court case; therefore, each accident record must be complete.

T F 17. A complete autopsy means that the scope of autopsy has been limited to a complete examination of all cranial contents.

T F 18. A patient's clothes list record becomes a part of the patient's medical record.

T F 19. It is the responsibility of the physician to determine whether all necessary authorizations have been included on each record.

T F 20. It is generally considered good practice to have the outpatient records conform to size and form of the records used for hospitalized patients.

T F 21. Although most hospitals tend to use basic records, the trend for teaching hospitals is toward the use of special records.

T F 22. Even though some special records forms are not considered as part of the medical record, they are often filed with the medical record to save confusion.

T F 23. Although the death certificate stub and the mortician's receipt for the body are considered essential, they are not filed in the medical record.

T F 24. A record of deficiencies should be kept on the summary sheet if at all possible.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. An obstetrical record, which is considered complete, contains a minimum of __________ parts.

2. Previous venereal, cardiac, pulmonary and renal diseases are recorded in the ______________ ______________ section of the prenatal reocrd.

3. Information concerning spontaneous and induced abortions is recorded in the ______________ ______________ section of the prenatal record.

4. A record on which information conernning the position and presentation of the ______________ is provided is called a labor record.

5. Minus and plus stations are indicated on the labor record, the distance of which is measured in ______________.

6. The term "presentation" refers to the relation which the long axis of the ______________ bears to the long axis of the ______________.

7. From birth of infant to expression of placenta is the ______________ stage of labor.

8. The physician's record of newborn reports the findings of the ______________ of the infant and is signed by the ______________

9. Generally, an infant at time of discharge should be turned over to the mother only, unless she is too ______________ to take it.

10. An accident report should be an accurate and complete record because every hospital case is a potential ______________ ______________ and this is especially true in accident cases.

11. An autopsy report is made out by a ______________ who also should sign the report.

12. When a therapeutic abortion is made, a special form must be signed by two ______________, one of which is an obstetrician.

13. The birth certificate stub or copy of birth certificate should be filed with the ______________ chart.

14. The ASA recommends that the administration of an anesthetic to an obstetrical oatient be recorded on a ______________ ______________ ______________.

15. A note should be made of all deficiencies on a ______________ record when assembling a medical record.

16. The graphic charts and nurses' notes are often combined into one record when a patient progresses to the ______________ stage.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The original form of the prenatal record is sent from the obstetrician to the (A) patient; (B) attending physician; (C) hospital; (D) attending nurse a few days before the expected delivery.

_____ 2. The scapula is the point of direction in a (A) brow; (B) occiput; (C) shoulder; (D) breech presentation.

_____ 3. The summary sheet for an infant should be filed (A) separately; (B) with the mother's; (C) either separately or with the mother's; (D) separately and with the mother's.

_____ 4. A day-by-day report of an infant's temperature and weight on a graphic weight chart is compiled by the (A) physician; (B) nurse; (C) medical record technician; (D) mother of the infant.

_____ 5. Permission for autopsy is signed by the (A) attending physician; (B) attending nurse; (C) responsible relative; (D) any of above three.

_____ 6. The release from responsibility for discharge form should be signed by the (A) patient or nearest relative; (B) attending physician; (C) attending nurse; (D) medical record librarian.

_____ 7. Information about living infants who are born before reaching full term should be entered on a (A) graphic chart; (B) postpartum chart; (C) nurses' record of infant; (D) premature infant record.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. A complete prenatal record includes the family history and:

(A)______________________ (E)______________________

(B)______________________ (F)______________________

(C)______________________ (G)______________________

(D)______________________

2. A complete newborn record consists of four parts:

(A)____

(B)____

(C)____

(D)____

3. The complete obstetrical reocrd consists of a minimum of three parts:

(A)______________________ (C)______________________

(B)______________________

Assignment
Sheet No. 6

Covering
Units 27-34

RESPONSIBILITY IN MEDICAL RECORD PREPARATION

All those who contribute data for records must accept their responsibility for completeness and accuracy in order to maintain adequate medical records. It is essential that the medical record department personnel know where the responsibility should be placed regarding the completion of the various sections of the medical record.

In this assignment you will have an opportunity to become familiar with the responsibilities of those who record data on medical records.

Assignment:

1. Read the reference listed below.
2. In view of your assigned duties in the hospital in which you work, write a report not over three pages in length to explain your responsibilities and relationship to the medical record.
3. Answer the questions below and turn in this assignment by ______________________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 159-190, 199-206.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is ture, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The attending physician has the major responsibility for maintaining an adequate medical record.

T F 2. From the very early days physicians have kept complete and accurate records regarding the care and treatment of patient.

T F 3. It is the responsibility of the attending nurse to obtain a complete report of the findings and procedures used by the physician in surgery.

T F 4. The attending physician must review the record for completeness prior to signing it at the time of discharge of the patient.

T F 5. The adequacy and completeness of medical records are a means of measurement in the accreditation of the hospital.

T F 6. According to the author, the medical record committee should contain one member from each service of the hospital.

T F 7. The medical record librarian may be consulted in the selection and appointment of members to the medical record committee.

T F 8. One of the responsibilities of the medical record committee is to study the trend of the clinical work in the hospital.

T F 9. The medical record committee should have the authority to pass judgment on the quality of records and to reject substandard records.

T F 10. The medical record department personnel actually make the regulations concerning medical records, while the medical record committee serves an advisory function.

T F 11. The medical record department personnel are responsible for making both the quantitative and qualitative analysis of medical records.

T F 12. The pathologist, the medical record librarian, and two other members of the medical staff make up the tissue committee.

T F 13. The medical record department can be the weakest department in the hospital, due largely to the substandard quality of the medical record.

T F 14. The governing board is legally responsible for a complete and accurate record of every patient treated in the hospital.

T F 15. When dictation is taken, the full names of the surgeons must be recorded.

T F 16. The less detailed a surgical report is the more valuable it becomes.

T F 17. The preoperative diagnosis should be recorded before the operation is started.

T F 18. Although mechanical devices are used for dictation purposes by doctors, they are very uneconomical especially when the volume of dictated material is great.

T F 19. The person in charge of the dictation pool is directly responsible to the medical record committee.

T F 20. The use of mechanical dictating devices aid in more prompt completion of records that form part of the medical record.

T F 21. The medical record librarian assists the medical staff committee by making the medical records available for their use.

T F 22. The JCAH is strongly against the practice of spot checking medical records by the medical record committee.

T F 23. The tissue committee does not review surgery cases where there is no tissue removed such as vaginal plastic repairs.

T F 24. Independent medical auditors usually are qualified medical record librarians.

T F 25. The medical record librarian may determine whether a consultation was requested, given, and recorded.

T F 26. The medical record librarian completes and files the psysician's index which is a permanent record of the individual physician's work.

T F 27. The information the medical record librarian gains when assisting in a medical audit is strictly confidential.

T F 28. The JCAH requires hospitals to have a medical audit committee in order to be accredited.

T F 29. The infection committee has a direct responsibility for the medical record.

T F 30. The medical record librarian usually works very closely with the utilization committee.

T F 31. It is doubtful if medical record, tissue, medical audit, infection, and utilization committee records would be admitted as legal evidence in court cases.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to combolete the sentence correctly.

1. The attending ________________, in the final analysis, must ascertain whether the record justifies the diagnosis and warrants the treatment and end results.

2. The Joint Commission on Accreditation of Hospitals requires that a ________________ ________________ ________________ be appointed to supervise and apprasse medical records and to insure their maintenance.

3. Tn case a staff member is delinquent in his records, the medical record librarian should notify the ________________ ________________.

4. The ________________ of service in a large hospital is generally responsible for reviewing the records on his service.

5. In order to avoid unnecessary duplication and to attain uniformity, medical record forms should clear through the medical ______________ ______________.

6. The tissue committee, which has some certain responsibility for the quality of care rendered patients, should meet at least once a ______________ and submit a report of its findings to the ______________ ______________ of the medical staff.

7. The ______________ ______________ has the final responsibility in all matters pertaining to hospital management.

8. The report of operation must be checked and signed by the ______________ prior to filing the chart in the medical record department.

9. Recorders and transcribers located in a dictation pool should be adjacent to the ______________ ______________ department.

10. The findings of the ______________ committee contribute to the quality of the surgical performance in the hospital.

11. The primary purpose of the tissue committee is to ______________ the surgery performed.

12. The medical ______________ committee has been defined as an ______________ method for applying a yardstick to the ______________ of professional performances.

13. The medical audit duties aremost commonly performed as an ______________ audit by a medical audit committee of the ______________ ______________.

14. The medical audit committee may require the ______________ ______________ ______________ to collect information for them.

15. The medical audit committee passes its written report and the cases it does not feel competent to judge onto the ______________ committee.

16. Medical accounting is usually done by the ______________ ______________ ______________.

17. Agreement or lack of agreement between provisional and final diagnosis is determined from the ______________ sheet, and these findings are then recorded on the medical ______________ work sheet.

18. Infections due to hospital produced ______________ strains of organisms has become an increasingly serious problem in recent years.

19. The infection committee is a policy setting, ______________ and ______________ committee.

20. The provision of an adequately equipped department for filing and indexing medical records is the responsibility of the ________________.

Multiple-Choice

Directions: In the space at the left of each statement write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The major responsibility for maintaining an adequate medical record concerning a case handled by an intern rests with the (A) intern; (B) attending physician; (C) medical record personnel; (D) all of these.

_____ 2. The medical record is kept primarily for the benefit of the (A) attending physician; (B) research value; (C) patient; (D) medical record librarian.

_____ 3. The medical record committee should report its findings to the executive committee every (A) week; (B) month; (C) six months; (D) year.

_____ 4. The medical audit committee (A) evaluates the surgical part of the medical record; (B) evaluates the quality of medical care given the patient; (C) does not evaluate any part of the medical record; (D) checks or audits the financial records of the hospital.

_____ 5. The medical audit committee should meet (A) once a week; (B) once a month; (C) every six months; (D) once a year.

_____ 6. Complications and classification of deaths are determined by the (A) medical auditor; (B) medical audit committee; (C) either A or B; (D) neither A nor B.

_____ 7. The Report of Hospital Infection is completed by the (A) charge nurse; (B) operating room supervisor; (C) attending physician; (D) by A, B, and C.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. Three major reasons for keeping an accurate medical record are:

(A)____

(B)____

(C)____

2. The medical recor

2. The medical record librarian must be acquainted with the essentials of a complete surgical report so that she can properly supervise the work of the:

(A)________________ (C)________________

(B)________________

3. The report of an operation should state the:

(A)________________________________

(B)________________________________

(C)________________________________

(D)________________________________

(E)________________________________

(F)________________________________

(G)________________________________

(H)________________________________

(I)________________________________

(J)________________________________

(K)________________________________

(L)________________________________

4. The medical record librarian usually works with the following committees:

(A)________________________________

(B)________________________________

(C)________________________________

(D)________________________________

(E)________________________________

5. The tissue committee and the report of the pathologist guard against the following four surgical malpractices:

(A)________________________________

(B)________________________________

(C)________________________________

(D)________________________________

6. The medical audit committee may have to classify medical findings under one of the following four classifications:

(A)____

(B)____

(C)____

(D)____

Assignment
Sheet No. 7

Covering
Units 35-42

MEDICAL TERMINOLOGY I

Terminology used in medical records is often confusing and puzzling to the beginner. These terms, most of which are of Greek and Latin origin, may be troublesome to learn unless the student uses a systematic approach. Some previous knowledge of these two languages will be of definite help to the medical record technician in her work in the medical record department.

In this assignment you will have an opportunity to become familiar with stems, prefixes, and suffixes that are used in the formation of medical terms.

Assignment:

1. Read the reference listed below.
2. Answer the questions below and turn in this assignment by ______________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 509-523.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. Derivation of the medical terms which are now in use was an arbitrary decision made in early times.

T F 2. Medical science grew up in a German environment.

T F 3. Most persons training for work in the medical record department have very little, if any, Greek and Latin background.

T F 4. Stems actually go back to a rather small number of monosyllabic elements known as prefixes.

T F 5. The suffix is attached to and precedes the stem.

T F 6. The disease terminology is much larger than the operative terminology.

T F 7. The original meaning of the component parts that make up a medical term may completely disappear.

T F 8. It is very possible that the French have had some influence on the medical terminology.

T F 9. It is possible that with a knowledge of stems, prefixes, and suffixes one can determine the meaning of medical terms without the use of a dictionary.

T F 10. Greek prefixes are normally used with Greek stems, whereas Latin prefixes are used with English stems.

T F 11. A suffix is generally a three- or four-syllable word.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. Almost all of the medical terms used are derived from the ______________ and ______________ languages.

2. The words of the Greek and Latin language go back to basic forms known as ______________.

3. Doublets refers to words that have come into the ______________ language by different routes.

4. Words that have the same sounds but different meanings are known as ______________.

5. A medical dictionary that supplies information on the ______________ of terms is essential to one working on medical records.

6. The ______________ is that part of the word that remains after the prefixes and suffixes have been removed.

7. A prefix is placed before a word to show certain ______________.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. One who is studying medical terminology is concerned mainly with stems of words to which the following are added:

(A) ______________________ (C) ______________________

(B) ______________________

2. Suffixes are generally divided into three classes according to use:

(A) ______________________ (C) ______________________

(B) ______________________

Matching

Directions: In the left hand column is a list of stems. The right hand column contains the meaning of these stems. Match the meaning of the stem to the corresponding stem by placing the letter of the meaning in the blank at the left of the stem to which it applies.

Group I--		Stems		Meaning
_____	1.	bronch	A.	arm
_____	2.	enter	B.	blood
_____	3.	galact	C.	uterus
_____	4.	arter	D.	cheek
_____	5.	colp	E.	skin
_____	6.	gloss	F.	intestine
_____	7.	cost	G.	crab
_____	8.	cervic	H.	bronchus or windpipe
_____	9.	brachi	I.	tongue
_____	10.	cyst	J.	rib
_____	11.	hem	K.	neck
_____	12.	hyster	L.	milk
_____	13.	derm	M.	artery
_____	14.	carcin	N.	bladder
_____	15.	bucc	O.	vagina

Group II--		Stems		Meanings
_____	1.	pyel	A.	uterus
_____	2.	metr	B.	hair
_____	3.	orchi	C.	urine
_____	4.	oophor	D.	breast
_____	5.	proct	E.	milk
_____	6.	lact	F.	testicle
_____	7.	ov	G.	pelvis
_____	8.	ur	H.	rectum
_____	9.	trich	I.	ovary
_____	10.	mast	J.	egg

Directions: In the left hand column is a list of prefixes. The right hand column contains the meaning of the prefix. Match the meaning of the prefix to the appropriate prefix by placing the letter of the meaning in the blank at the left of the prefix to which it applies.

Prefixes I

_____	1.	infra	A.	excessive
_____	2.	dis	B.	before
_____	3.	circum	C.	separation
_____	4.	hyper	D.	lower
_____	5.	atel	E.	within
_____	6.	contra	F.	both
_____	7.	dys	G.	half
_____	8.	cata	H.	away from
_____	9.	demi	I.	through
_____	10.	ambi	J.	around
_____	11.	dia	K.	similar
_____	12.	endo	L.	imperfect
_____	13.	homeo	M.	below
_____	14.	ante	N.	painful
_____	15.	ab	O.	opposite

Prefixes II

_____ 1. pro
_____ 2. steno
_____ 3. juxta
_____ 4. retro
_____ 5. polio
_____ 6. meso
_____ 7. super
_____ 8. pro
_____ 9. trans
_____ 10. mega
_____ 11. uni
_____ 12. ortho
_____ 13. sapro
_____ 14. para
_____ 15. ob

A. great
B. forward
C. against
D. one
E. narrow
F. straight or normal
G. across
H. gray
I. backward
J. middle
K. putrid
L. forward
M. near
N. beyond
O. above, over

Directions: In the left hand column is a list of suffixes. The right hand column contains the meaning of the suffix. Match the meaning of the suffix to the appropriate suffix by placing the letter of the meaning in the blank at the left of the suffix to which it applies.

Suffixes

_____ 1. an

_____ 2. cele

_____ 3. ectomy

_____ 4. id

_____ 5. tomy

_____ 6. lysis

_____ 7. taxis

_____ 8. ia

_____ 9. clasis

_____ 10. rhea

_____ 11. itis

_____ 12. pexy

_____ 13. oid

_____ 14. oma

_____ 15. cyte

A. resembling

B. surgical fixation

C. flow

D. destroy

E. inflammation

F. loosen

G. cutting out

H. pertaining to

I. like

J. a morbid condition

K. hollow vessel

L. diseased condition

M. hernia

N. order

O. incision

Assignment
Sheet No. 8

Covering
Units 43-49

MEDICAL TERMINOLOGY II

As one becomes more familiar with the work of the medical record department, the importance of a thorough knowledge of medical terms and their meanings and uses becomes more evident. The student must not only know the stems, prefixes, and suffixes that make up the many medical terms, but also other scientific and nonscientific descriptive terms and abbreviations that are used in hospital work and affect the patient's medical record.

In this assignment you will have an opportunity to become familiar with plural noun formations, homonyms, eponyms, common disease terms, abbreviations, and hospital terms.

Assignment:

1. Read the reference listed below.
2. Answer the questions below and turn in this assignment by ____________________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 523-548.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter""T." If it is false, draw a circle around the letter "F."

T F 1. Many of the plural nouns in medical terminology are formed from singular nouns which are derived from Latin and Greek.

T F 2. Digiti is the plural from of digitus.

T F 3. Adduction is a descriptive term applied to a person who is in a state of being addicted.

T F 4. Eponyms are universally used by medical record personnel for classification purposes.

T F 5. It is possible that even if an eponym is used one may still not know the disease being referred to.

T F 6. All commonly used disease eponyms have other diagnosis titles listed in the Standard Nomenclature book.

T F 7. The term bradycardia means an abnormal slowness of the heartbeat.

T F 8. Friction is the extract from liver used to treat pernicious anemia.

T F 9. Any one of a group of kidney diseases attended with albuminuri and edema is commonly referred to as Bright's disease.

T F 10. Jackson's veil is a term referring to a delicate curtain or web of adhesions which is also called membranous pericolitis.

T F 11. Every hospital should recognize only the medical abbreviations recognized by the AMA.

T F 12. The numerical evaluation of the respiratory condition of a newborn infant is called the apgar score.

T F 13. A contagious disease may be one communicable by contact with an object.

T F 14. A communicable disease is one whose causative agent can be passed on to another person only by direct contact with the diseased person.

T F 15. A fracture is generally considered as an emergency case.

T F 16. A new birth is not considered as a hospital admission.

T F 17. An infectious disease is one that is caused by parasites and is always considered as contagious.

T F 18. An inpatient is any individual who occupies a hospital bed while receiving hospital care.

T F 19. Deaths resulting from abortions are generally not classified as maternal deaths.

T F 20. Even though communication between a doctor and patient is confidential, the parties can legally be compelled to disclose it as witnesses.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. When in doubt concerning medical terms, medical record personnel should consult a good ______________.

2. The term oral pertains to the ______________, while the term aural pertains to the ______________.

3. Physicians and surgeons use eponyms for both diseases and _______________.

4. A term used to denote the operation of making an incision into the bladder is _______________.

5. A disease eponym term for the fracture of the lower third of the fibula is _______________ _______________.

6. An operation eponym term for a gastrectomy is _______________ operation.

7. The medical term "herpes of lip" is usually called _______________ _______________ by laymen.

8. The abbreviation "min." stands for _______________.

9. The number of beds normally available for use by infants born in the hospital is called _______________ _______________ capacity.

10. The meanings of unfamiliar hospital terms may be looked up in a book called _______________ _______________ _______________ published by the American Hospital Association.

11. A _______________ diagnosis is based on gross and microscopic examinations of the structural lesions present.

12. A diagnosis based upon symptoms shown during life, irrespective of the morbid changes producing them, is called a _______________ diagnosis.

13. The three types of patient days are adult, _______________, and _______________.

14. A hospital term used for an infant's death which occurs less than 28 days after delivery is _______________ _______________.

15. A person who is receiving dental services in a hospital is called a _______________.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The plural form of varix is (A) varixs; (B) varixes; (C) varices; (D) varies.

_____ 2. A term meaning a tooth socket or a sac in the lining is (A) asepsis; (B) alvus; (C) alveus; (D) alveolus.

_____ 3. The membrane containing the heart is the (A) peritoneum; (B) pericardium; (C) perivesical; (D) perineal.

_____ 4. A term used to denote disorder of the mind is (A) psychosis; (B) separation; (C) serosa; (D) sycosis.

_____ 5. A hospital term for a postmortem examination is (A) material death; (B) neonatal death; (C) necropsy; (D) protocol.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. Four general kinds of treatment are:

(A)______________________ (C)______________________

(B)______________________ (D)______________________

Matching

Directions: In the left hand column is a list of homonyms and other terms. The right hand column contains the meanings of these terms. Match the meanings of these terms by placing the letter of the meaning in the blank at the left of ahe appropriate term.

_____ 1. contusion

_____ 2. stasis

_____ 3. epidemic

_____ 4. lymphadenitis

_____ 5. palpation

_____ 6. staxis

_____ 7. hypertension

_____ 8. carpus

_____ 9. cirrhosis

_____ 10. hypotension

_____ 11. concussion

_____ 12. lympangitis

_____ 13. endemic

_____ 14. serosa

_____ 15. corpus

A. the wrist

B. a violent jar or shock

C. disease of the liver

D. hemorrhage

E. abnormally high tension

F. a disease prevalent in a certain district

G. any serous membrane

H. inflammation of lymphatic vessels

I. lower tension

J. the body

K. stoppage of flow of blood in any part

L. locating by touch

M. a bruise

N. inflammation of lymph glands

O. a disease which is widely prevalent

Directions: In the left hand column is a list of disease eponyms. The right hand column contains the diagnosis according to the Standard Nomenclature. Match the diagnosis to the eponym by placing the letter of the diagnosis in the blank at the left of the appropriate eponym.

_____ 1. Hunner's ulcer
_____ 2. St. Vitus' dance
_____ 3. Pick's disease
_____ 4. Buerger's disease
_____ 5. Addison anemia
_____ 6. Duhring's disease
_____ 7. Charcot's joint
_____ 8. Graves' disease
_____ 9. Parkinson's disease
_____ 10. Dietl's crisis
_____ 11. Pott's disease
_____ 12. Paget's disease of bone

A. angulation of ureter
B. osteitis deformans
C. neurogenic arthropathy
D. paralysis agitans
E. pernicious anemia
F. tuberculosis of vertebra
G. interstitial cystitis with ulceration
H. toxic diffuse goiter
I. dermatitis herpetiformis
J. polyserositis
K. chorea
L. thromboangiitis obliterans

Directions: In the left hand column is a list of operation eponyms. The right hand column contains the scientific medical term or description of the operation. Match the scientific medical term or description to the eponym by placing the letter of the scientific term or description in the blank at the left of the appropriate eponym.

_____ 1. Whitehead operation
_____ 2. Hibbs' operation
_____ 3. Verhoeff's operation
_____ 4. Sluder's operation
_____ 5. Caldwell-Luc operation
_____ 6. Albee's operation
_____ 7. Bassini operation
_____ 8. Ramstedt operation
_____ 9. Porro operation
_____ 10. Sturmdorf operation

A. spinal fusion; spondylosyndesis
B. removal of the tonsil along with its capsule
C. repair of hernia
D. hemorrhoidectomy
E. maxillary antrotomy, radical
F. conical excision of endocervix
G. Cesarean section followed by removal of uterus
H. pyloromyotomy
I. spinal fusion technique
J. detachment of the retina

Directions: In the left hand column is a list of common medical disease terms. The right hand column contains lay terms. Match the lay term to the respective medical term by placing the letter of the lay term in the blank at the left of the appropriate medical term.

_____	1.	Rubella	A.	bruise
_____	2.	Verruca	B.	Ague
_____	3.	Vincent's angina	C.	lice
_____	4.	unguis incarnatus	D.	nose bleed
_____	5.	Malaria	E.	wart
_____	6.	zoster	F.	trench mouth
_____	7.	contusion	G.	pink eye
_____	8.	epistaxis	H.	shingles
_____	9.	pediculosis	I.	German Measles
_____	10.	conjunctivitis	J.	ingrown nail

Directions: In the left hand column is a list of abbreviations. The right hand column contains the English or Latin definition. Match the definition to the abbreviation by placing the letter of the definition in the blank at the left of the appropriate abbreviation.

_____ 1. alt. noct.

_____ 2. t.i.d.

_____ 3. decub.

_____ 4. Omn. hor.

_____ 5. ung.

_____ 6. C. S. F.

_____ 7. Hg.

_____ 8. dil.

_____ 9. noct.

_____ 10. b.i.d.

_____ 11. q. h.

_____ 12. liq.

_____ 13. quotid

_____ 14. ad. lib.

_____ 15. sol.

A. lying down

B. solution

C. at night

D. daily

E. every hour

F. twice daily

G. every other night

H. a liquid solution

I. as desired

J. three times a day

K. every hour

L. hemoglobin

M. dilute

N. cerebrospinal fluid

O. ointment

Directions: In the left hand column is a list of medical and surgical specialty terms. The right hand column contains the meaning of these terms. Match the meanings to the terms by placing the letter of the meaning in the blank at the left of the appropriate term.

_____ 1. rhinology

_____ 2. psychiatry

_____ 3. surgery

_____ 4. proctology

_____ 5. dietetics

_____ 6. orthodontia

_____ 7. oncology

_____ 8. neurology

_____ 9. otorhinolaryngology

_____ 10. geriatrics

_____ 11. laryngology

_____ 12. obstetrics

_____ 13. pharmacology

_____ 14. therapeutics

_____ 15. anesthesiology

A. the science of nutrition

B. study of anesthesia and anesthetics

C. study and treatment of the throat

D. study and treatment of women during pregnancy

E. study and treatment of tumors

F. study of nature and properties of drugs

G. study and treatment of disease of old age

H. treats diseases by manual or operative means

I. the science and art of healing

J. study of prevention and correction of irregularities of the teeth

K. study of the nose and its diseases

L. study and treatment of diseases of rectum, etc.

M. study and treatment of disease of central, etc., nervous systems except those requiring operative treatment

N. study of the mind and its disorders

O. study and treatment of diseases of the ear, nose, throat

Assignment
Sheet No. 9

Covering
Units 50-58

FILMING AND FILING MEDICAL RECORDS

Hospital facilities are being used more and more by our increasing population. This in turn has increased the need for more adequate medical records and has also demanded a more accurate, efficient, and systematic method of handling the growing multiplicity of records. The value of the records is of increasing importance, not only to the accrediting association, but also to the physician, the hospital and the patients involved.

Undoubtedly one of the most important responsibilities of the personnel of the medical record department is to become thoroughly familiar with the various methods of handling and preserving medical records.

In this assignment you will have the opportunity to become familiar with the various methods of numbering and filing records as well as the filming and storing of these records.

Assignment:

1. Read the reference listed below.
2. Become thoroughly familiar with the numbering and filing systems used in the hospital in which you work. Write a five-page report explaining the systems which are used and their advantages and disadvantages.
3. Answer the questions below and turn in this assignment by ____________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 207-245, 261-276.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. Of the various numbering methods used in hospitals, the use of admission numbers has the greatest disadvantage.

T F 2. If the patient's index card is lost in a system using the diagnosis classification method, the respective patient's medical record becomes lost.

T F 3. The patient's admission number and name is located on the patient's register.

T F 4. A patient is assigned a different number for each new admission under the serial numbering system.

T F 5. When using the serial number system, a patient's medical records may be filed in one or more places in the file.

T F 6. A patient is assigned a new admission number upon each readmission under the serial-unit system.

T F 7. A simple usable method to indicate the location of a record moved forward under the serial-unit method is to leave the empty original folder in the file and include the new number of admission.

T F 8. Ease of filing is one of the chief advantages of both the serial-unit and the serial method.

T F 9. Under the unit method of numbering the patient retains and uses the same number received upon his first admission.

T F 10. The master summary sheet saves considerable time when used to refer to the unit record of a patient.

T F 11. An advantage of the master summary sheet is that it provides at a glance a picture of the medical history of the patient during all hospitalizations.

T F 12. Many hospitals are changing from a serial to a unit system although this is a very difficult procedure.

T F 13. The inpatient and outpatient departments file records independently within their departments in a centralized filing system.

T F 14. Under a decentralized system the records of the patient from the outpatient and inpatient departments are combined following the discharge of the patient.

T F 15. Only the unit and serial numbering systems may be used with the decentralized filing system.

T F 16. A decentralized system should be used in hospitals only if lack of space prevents the use of a centralized system.

T F 17. Only the unit method of numbering should be used in the centralized system of filing.

T F 18. When using the centralized unit system, all of the patient's records, whether inpatient or outpatient, are kept in the same folder under one number.

T F 19. Although terminal digit filing is speedy, it is a very difficult method to learn.

T F 20. When using the terminal digit method of filing, six or more digit numbers must be used.

T F 21. The promptness with which medical records are filed is a good test of efficiency of the medical record department.

T F 22. A medical record should never be removed by anyone except by a member of the medical record department.

T F 23. The general practice is to file medical records behind the file guides rather than in front.

T F 24. Having only one person responsible for the files aids in preventing misfiling.

T F 25. Certain practices followed in preventing and locating misfiles have been borrowed from the business and commercial world.

T F 26. It is rare for information to be sought from the medical record when 10 years have passed since the last discharge.

T F 27. The American Hospital Association recommends that medical records of patients be kept indefinitely.

T F 28. The volume of medical records is constantly increasing.

T F 29. Hospitals were the first group to use microfilming techniques for purposes of preserving bulk material.

T F 30. About 75-80% of the space can be saved when microfilm rolls are used.

T F 31. A decided disadvantage of microfilms is their short life expectancy as compared to original records.

T F 32. A much greater fire hazard exists in medical records departments which store records on microfilm.

T F 33. Microfilmed records are considered as primary evidence in legal matters.

T F 34. Many hospitals keep medical records in their original form for the length of time provided by the statute of limitations in the particular state.

T F 35. Before filming records a survey of readmissions should be made.

T F 36. The decision of whether to film a medical record in entirety is up to the medical record librarian.

T F 37. To do good work when filming records, the actual work should be done by one person familiar with the work and the machine.

T F 38. Each medical record sheet should be destroyed immediately after it has been filmed to avoid later confusion.

T F 39. In some hospitals it might be advisable to have microfilming done by a commercial company rather than rent or buy a machine for the work.

T F 40. To insure against loss, many hospitals have two microfilm copies made of the original medical record.

T F 41. It is less costly to place microfilms on cards than to leave them in the roll form.

T F 42. Various types of paper cards are used for holding microfilmed records.

T F 43. When converting to the terminal digit system, it is most practical to convert only the more active files.

T F 44. The best policy when doing a file conversion job is to hire outside help.

T F 45. When converting a file, the records should be sorted first according to the final number, then the secondary and finally the primary number.

T F 46. File clerks should be assigned "at large" to the whole file area so that they are intimately familiar with the whole department.

T F 47. Color-coded folders are a great help when looking for a special record in a stack of medical records being processed

T G 48. Activity checks can be made quickly and throughout the year by placing an activity column on the outside front cover of the folder.

T F 49. A 24 hour notice is usually required for medical record requisition requests from the floor or clinic.

T F 50. The JCAH has a specified set of standards governing the retention and preservation of medical records.

T F 51. The master patients' index is retained for 25 years or until the Statute of Limitations is exhausted.

T F 52. Many hospitals have adopted microfilming to relieve file congestion rather than rent commercial storage space or build additional storage wings.

T F 53. The validity of medical records microfilmed by an outside contractor can be preserved by obtaining a statement of authenticity meeting U. S. Bureau of Standards.

T F 54. Though color-coding is useful for filing medical record folders, it serves no functional value when filing microfilm jackets.

T F 55. The only profitable use that hospitals can make of the microfilm process is to film medical records.

T F 56. The new scroll microfilm and retrieval process can be used only with a computer.

T F 57. A drawback of the new scroll microfilm and retrieval process is that the transfer of the film to card mounts utilized in conventional readers is costly and time consuming.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. The ______________ and the ______________ are the two filing arrangements generally used in medical record departments.

2. Of the various methods of numbering, the use of ______________ numbers has the same disadvantage as the use of diagnosis classification numbers.

3. The method of filing patients' records almost universally used today is that of filing records under ______________ numbers.

4. The admission number used for a new case under the serial numbering system is the next unused number in either the ______________ ______________ or the number index.

5. When moving charts forward in the serial-unit system, a marker must be left where the record was taken out to indicate the ______________ of the chart.

6. When using the unit numbering system, the file drawers should not be filled to more than __________ per cent of the capacity.

7. A new series of numbers should be started after reaching the number of __________ except when terminal digit filing is used.

8. The ______________ filing system is rapidly being replaced by the ______________ filing system.

9. The two types of filing equipment are ______________ and ______________ ______________.

10. In a ______________ system, all inpatient and outpatient records are filed in a central department.

11. The person assigning numbers in a centralized unit system should keep a ________________ book indicating numbers assigned to each department.

12. A method of filing being adopted by the larger hospitals is the ________________ ________________ or reverse numerical filing method.

13. When using the terminal digit method of filing, the first two digits on the right hand side of the number are called the ________________ number and the two immediately to the left of th these are called the ________________ number.

14. The use of ________________ filing can save from ______ to ______ per cent on the conventional file cabinet.

15. Numbers are assigned with a terminal digit system just as they would be for a ________________ or ________________ system.

16. A requisition and __________________________ system of control should be followed so that the location of a given medical record may be determined.

17. An ________________ is placed in the file when a chart is removed which shows the date the medical record went out and where it went.

18. Guide tab openings should have the ________________ number printed in ________________ as the top number and the ________________ number printed in ________________ just below the top number.

19. The microfilming technique actually dates back to the year of __________.

20. Between 1930 and 1940 microfilming ceased to be considered a photographic technique but rather a ________________ ________________ and control system.

21. Filming records is made easier if the ________________ ________________ is written on a sheet preceding each chart which is called a target sheet.

22. Of the two, preparation and filming of records, the _______________ is considered more difficult.

23. The boxes of microfilms are filed ________________ after they have been properly labeled.

24. The primary objective of all hospitals in filming medical records is to ________________ ________________

25. Medical records are filmed on ________ - foot rolls, then cut into strips each containing the records of one patient after which they are again cut and inserted into cards.

26. The use of cards for microfilmed records has brought about a tendency to film medical records up to within ________ or ________ years of discharge.

27. Though rarely found, the ideal file area of 100 terminal digit sections would have ________ stacks of ________ shelves each.

28. The major purpose for color coding file folders is to ________________ ________________.

29. Color-code should be printed in a narrow band on both the ________________ ________________ and ________________ ________________ of the folder.

30. Files can be kept quite compact by shifting records which have been inactive for ________ years to a secondary file room.

31. A sorter similar to a mail sorter should be utilized when ________ or more medical records per day are turned in for filing.

32. Generally ________________ numerical filing is used in secondary file rooms so that records will be in order for microfilming.

33. When a color-coded medical record folder is removed from the file, it should be replaced by a ________________ color-coded ________________ to designate where the record is taken.

34. Greater efficiency can be gained by providing telephone extensions with the ________________ ________________ coded to the numbers of th terminal digit.

35. It usually requires ________ man-days to prepare, microfilm, and edit the medical records filed in ________ and one-half standard letter-size file drawers.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

______ 1. The preferred method of numbering used in filing documents concerning patients is (A) discharge; (B) admission; (C) diagnostic classification code; (D) none is preferred.

______ 2. When a hospital uses a serial numbering system (A) more (B) less; (C) same; (D) same time is required for gathering all of the patient's records upon his readmission.

______ 3. Under the serial-unit numbering system, all previous records of the patient are brought up under the (A) first; (B) middle; (C) last; (D) either first or last admission number given the patient.

______ 4. When using the central unit system (A) one person; (B) the outpatient department; (C) the inpatient department; (D) both the inpatient and outpatient departments should assign unit numbers to patients.

______ 5. If the admission number of a patient is 769382 in terminal digit filing, the digits called the secondary number are (A) 76; (B) 69; (C) 93; (D) 82.

______ 6. The primary numbers of a terminal digit file range up to (A) 50; (B) 49; (C) 100; (D) 99.

______ 7. When using color to assist in filing, the number of colors generally considered adequate for coding the primary numbers is (A) 5; (B) 10; (C) 100; (D) 1000.

______ 8. Research study from microfilm as compared to the original medical record is (A) easier; (B) more difficult; (C) neithe easier nor more difficult; (D) impossible.

______ 9. Microfilming should be done (A) weekly; (B) monthly; (C) every six months; (D) annually.

______ 10. The enlarged image of the projected microfilm as compared to the original medical record is usually (A) the same size; (B) larger; (C) smaller; (D) none of these.

Matching

Record Retention

The left hand column below contains names of various records and the right hand column, various retention periods. Match the time with the name by placing the letter of the retention period in the blank provided to the left of the name of the record.

_____ 1. Nurses bedside record

_____ 2. Emergency room records

_____ 3. Patient and delivery room registers

_____ 4. Operation registers

_____ 5. Disease and operation indexes

_____ 6. Physicians' index

_____ 7. Operating room schedules

_____ 8. Admission and discharge lists

_____ 9. Daily hospital service analysis reports

_____ 10. Narcotic records

A. Usually kept 5 years with a maximum period of 10 years

B. Kept up to two months

C. Kept the cycle time required for specific medical staff studies

D. Usually kept two years

E. Kept permanently if used as a number index, otherwise, kept for a 2 year maximum

F. Should be kept permanently

G. Removed from medical records and filed chronologically in some other place until the State of Limitations expires

H. U. S. Treasury Dept. requires that they be kept 2 years

I. Preserved for 10 years

J. Usually kept only until the Statutes of Limitations for negligence or malpractice has expired

Listing

Directions: List the items called for in each of the following. Select Your answers carefully.

1. The methods of numbering accepted as adequate in medical record practice are:

(A) _____________________ (C) _____________________

(B) _____________________

2. The systems of filing accepted as adequate in medical record practice are:

(A)____________________ (B)____________________

3. When using the admission number filing method, missing or lost records due to lost patient-index cards may be located through the identification number on:

(A)____________________ (C)____________________

(B)____________________

4. Besides the patient's name and birth date, the master summary sheet contains the following information:

(A)____________________ (D)____________________

(B)____________________ (E)____________________

(C)____________________ (F)____________________

5. Four advantages of the terminal digit filing method are:

(A)____

(B)____

(C)____

(D)____

6. Medical records are retained and preserved for the following three purposes:

(A)____

(B)____

____

(C)____

7. The five advantages in microfilming records are:

(A)____________________ (D)____________________

(B)____________________ (E)____________________

(C)____________________

8. The three major advantages of shelf filing are:

(A)____

____

(B)____

(C)____

____

9. List four important tasks that should be done when converting a file to the terminal digit system:

(A)____

(B)____

(C)____

(D)____

____

10. List the steps necessary to prepare a medical record for microfilming:

(A)____

(B)____

(C)____

____

(D)____

(E)____

Assignment
Sheet No. 10

Covering
Units 59-64

NOMENCLATURE OF DISEASES AND OPERATIONS

Various classifications for diseases and operations have been devised and used through the years. These different nomenclatures made it very difficult for anyone to make any type of comparative study of the work done in the various hospitals. It was not until during the present century that the forerunner of the presently accepted Standard Nomenclature of Diseases and Operations was begun.

The personnel of the medical record department must become thoroughly familiar with the Standard Nomenclature and its use and must constantly keep up to date with the new additions. This book is a guide and may even be considered the bible for the medical record department.

In this assignment you will have an opportunity to become familiar with the Standard Nomenclature of Diseases and Operations, and its use in the work of the personnel of the medical record department.

Assignment:

1. Read the reference listed below.
2. Study pages 284 through 310 of the reference. Select or have the medical record librarian select diagnoses that have not been coded. By consulting the Standard Nomenclature of Diseases and Operations and the reference, complete the code numbers for these diagnoses. Have the librarian check your work. Continue this until you become thoroughly familiar with the use of the SNDO.
3. Answer the questions below and turn in this assignment by ____________________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 277-314.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The term "nomenclature" as used in medical science may be defined as a systematic compilation of terms of diseases, conditions, and operations.

T F 2. A nomenclature of disease was published as early as 1869 in London and contained equivalent terms in English, German, and Latin, which were the richest languages in medical learning and literature at that time.

T F 3. By the mid-1850's, the thinking was already toward a nomenclature that could be used by many countries.

T F 4. A Provisional Classification of Diseases and Injuries for Use in Compiling Morbidity Statistics was published in Great Britain.

T F 5. The Standard Nomenclature of Diseases and Operations was the first nomenclature publication produced in the United States.

T F 6. In 1874 a Nomenclature of Diseases was compiled in the United States that was based on the Nomenclature of Diseases of the Royal College of Physicians.

T F 7. The United States Public Health Service prepared a Nomenclature of Operations in 1916.

T F 8. The etiological factor was used for grouping in the publication, in the early 1900's, of A Terminology of Diseases.

T F 9. A feature of the Terminology of Operations of the University of Chicago Clinics is that it had a complete list of synonyms for reference.

T F 10. An M. D. and R.R.L. cooperated in compiling The New York Hospital Nomenclature of Operations published in 1938.

T F 11. The American Medical Association sponsored the original publication of the Standard Classified Nomenclature of Disease.

T F 12. Code numbers (digits) were used to designate the site of the disease and the etiology in place of the name of the disease in The Standard Classified Nomenclature of Disease.

T F 13. The American Medical Association is responsible for the revision of the Standard Nomenclature of Diseases and Operations.

T F 14. Of the many different types of disease classifications, the medical record department is primarily concerned with information regarding the causative agent and its bearing on the part of the body affected.

T F 15. A basic factor important in the compilation of any disease nomenclature is that the terms applied to diseases indicate as far as possible the true nature of the diseases.

T F 16. It is the responsibility of the medical record librarian to do the coding of diseases and operations in the small hospital.

T F 17. The Standard Nomenclature of Diseases and Operations is based on a single system of classification.

T F 18. Topographical and procedural classifications are the two used in the operative nomenclature of the Standard Nomenclature.

T F 19. The topographical classification is the same for both the disease and the operation nomenclature in the Standard Nomenclature.

T F 20. The maximum number of subdivisions in a topographic classification is four.

T F 21. At times decimals are used to indicate additional subdivision of the etiological categories.

T F 22. The medical record personnel must never make up numbers to designate disease or operative procedures.

T F 23. The cross-index cards on diseases are filed in the same sequence as the diseases are listed in the Standard Nomenclature.

T F 24. Incomplete diagnoses are represented in the Standard Nomenclature by incomplete code numbers.

T F 25. The master code numbers must never be changed, although at times substitutions may be made.

T F 26. Master code numbers are found in both the etiological and topographical sections of code numbers in the nomenclature.

T F 27. It is very possible that both the topographical and etiological part of a code number (a master code number) must be completed.

T F 28. When an etiological master code number starts and ends with a digit separated by three points, the last figure is usually a decimal digit.

T F 29. The purpose of open-end code numbers is to conserve space in the Standard Nomenclature book.

T F 30. The open-end code number is the same as a master code number.

T F 31. It would be very helpful to a medical record librarian to have a thorough knowledge of anatomy when coding diagnoses listed in the nomenclature under master and open-end code numbers.

T F 32. Decimal digits are used much more frequently in the topographical sections than in the etiological.

T F 33. A principle to be followed is that a decimal cannot be added to a code number which already contains a decimal.

T F 34. Decimal digits are added when it is desirable to show end results to completely code the condition.

T F 35. In the etiological category, the dual lists of code numbers always have the same meaning.

T F 36. Decimal digits always precede the basic code numbers.

T F 37. If a behavior code letter is used with the basic code number, the decimal may either precede or follow this letter, depending on the particular case.

T F 38. In some instances decimal digits may be found in both the topographical and etiological part of the particular code number.

T F 39. When a behavior code letter is assigned as a part of the basic code number, it should never be dropped.

T F 40. If the behavior code letter is a part of the number listed in the nomenclature, it may be assumed that it is part of the basic code number.

T F 41. The use of behavior code numbers are especially useful in hospitals where research is carried on.

T F 42. Certain diagnoses very closely related are grouped together in the Standard Nomenclature under the same code number.

T F 43. When the cause of a disease is recognized as unknown to medical science, the categories 9 and x are used.

T F 44. Supplementary terms should only be used by physicians to complement a diagnosis.

T F 45. The code number y00-y00 indicates an undiagnosed disease.

T F 46. Procedural classification has eleven divisions.

T F 47. The procedural classifications are subdivided in a similar way to the topographical and etiological divisions.

T F 48. In hospitals where research is done in anesthesia, an anesthesia cross index should be set up under the auspices of the anesthesia department.

T F 49. The SNDO includes indexes for both the disease and operation nomenclatures.

T F 50. The use of eponyms is discouraged since their use many times makes it difficult to assign the correct code number.

T F 51. The first step to follow when checking code numbers thought to be incorrect is to look for the name of the organ in the index.

T F 52. An eponym is a name of a part, organ, disease, etc., to which the name of a person is attached.

T F 53. The Current Medical Terminology published by the AMA is an updated revision of the SNDO.

T F 54. The Current Medical Terminology is an alphabetical listing of disease and operative terms.

T F 55. Though useful to the medical staff, the CMT is of little value to the medical record librarian when coding or indexing

T F 56. The arbitrary serial numbers found in the CMT are useful to the medical record librarian when coding or indexing.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. The term "nomenclature" literally signifies a calling of ________________.

2. The most generally used nomenclature at the beginning of the nineteenth century was known as the ________________ ________________ ________________.

3. The first disease nomenclature comparable to our presentday classification was published in the year of ________ in the country of ________________ ________________.

4. A majority of the nomenclatures of diseases have based the terminology of their anatomical classification on a report made in 1895 known as the ________________ ________________ ________________

5. The first nomenclature of diseases to be used extensively in the United States but which was discontinued in favor of the Standard Nomenclature was the ________________ ________________ Nomenclature of Diseases.

6. The last edition of the ________________ of ________________, published in 1931, used etiological disease terms and grouped the 42 sections by systems using title numbers of the Manual of the International List of Causes of Death.

7. A nomenclature which was an alphabetical list of diagnoses and operations was first published in 1927 under the title of ________ ____________ ____________ of Diseases and Operations.

8. The forerunner of the present Standard Nomenclature of Diseases and Operations was The Standard ____________ ____________ of ____________.

9. In the first issue of The Standard Classifies Nomenclature of Disease each disease was classified according to both its ____________ location and the ____________ or cause.

10. The Standard Nomenclature of Disease and The Standard Nomenclature of Operations was published in one volume for the first time in the year of ________.

11. A basic factor important in the compilation of any disease nomenclature is that related diseases appear under ______ heading.

12. The disease nomenclature of the Standard Nomenclature has the following two basic classifications, ____________ and etiological.

13. The first digit in the topographical code number in the Standard Nomenclature indicates the ____________, the second denotes the ____________ or ____________ and the third the specific ____________ of the organ or part affected.

14. The two procedures used in handling master code numbers are ____________ and ____________.

15. The master code numbers may be considered as ____________ codes because they indicate a minimum of the topographical section concerned.

16. Open-end code numbers occur in the part of the nomenclature concerned with ____________ and ____________ diseases.

17. When basic topographical and etiological code numbers are not adequate, ____________ digits are added to provide further specification.

18. A synonymous code number for -100.2 (abcess) is ________.

19. Behavior code numbers are attached to the etiological numbers for ____________ in order to describe the behavior or malignancy of tumors.

20. If the location or cause of disease has not been conclusively decided upon by the physician by the time of discharge of the patient, the letter ______ is used.

21. The last group of cards in each section of the disease index is the ________________ diseases.

22. The operative procedure codes at the SNDO consist of ________ to ________ digits only.

23. In the nomenclature of operations, the code letter x indicates an ________________ method of approach and y indicates a ________________ ________________ or alternate method.

24. The last section of the main part of the Standard Nomenclature is the ________________ section.

25. The tools for finding the appropriate code numbers in the Standard Nomenclature are the ________________.

26. The indentations in both the disease and the operation indexes are used to indicate various ________________ of the preceding term.

27. The appendix of the SNDO contains an abridged statistical classification of diseases designed for use by ________________ ________________ employing manual methods of indexing.

28. The Current Medical Terminology was first published in ________ and is an alphabetical listing of ________ current disease terms.

29. The SNDO lists approximately ________ disease terms.

30. The primary purpose of the Current Medical Terminology is to assist the ________________ to find the appropriate ________________ term for use in a specific case.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. A Nomenclature of Diseases was compiled by a committee appointed by the AMA un 1869 which used the English terms and (A) Greek; (B) Latin; (C) French; (D) all three equivalents.

_____ 2. The edition of the List and Classification of Diagnoses and of Operative Procedures published in 1916 and 1928 was grouped by (A) anatomical structures; (B) systems; (C) systems and anatomical structure; (D) none of these.

_____ 3. The topographical classifications are divided into (A) 7; (B) 9; (C) 11; (D) 13 main anatomic divisions which should be memorized.

______ 4. The number of main etiological categories in the Standard Nomenclature is (A) 7; (B) 9; (C) 11; (D) 13.

______ 5. The following number is the specific site affected by the disease or operated upon (A) -55; (B) 7-; (C) 687-; (D) -687.

______ 6. The following is an example of a master code number in the etiological section of the Standard Nomenclature (A) 456-; (B) 456; (C) 4..-; (D) -4

______ 7. It is the responsibility of the medical staff and the (A) medical record librarian; (B) admissions officer; (C) pathologist; (D) head nurse to decide whether behavior code numbers are to be used.

Matching

Directions: In the left hand column is a list of topographical and etiological classification numbers. The right hand column contains the specific meaning of these numbers. Match the meaning of the classification number to the appropriate number by placing the letter of the meaning in the blank at the left of the number.

______ 1. -3

______ 2. 78-

______ 3. -400.x

______ 4. -y

______ 5. 8-

______ 6. -400.0

______ 7. -42

______ 8. 733

______ 9. -400.3

______ 10. 7883

______ 11. -46

______ 12. 72-

______ 13. -8

______ 14. 7893

______ 15. 0-

A. cervix uteri

B. diseases of undetermined cause

C. renal pelvis and ureter

D. epoophoron

E. fistula; sinus; perforation

F. remote effects of trauma

G. internal female organs

H. impairment, disturbance, or loss of function

I. sacrouterine ligament

J. endocrine system

K. body as a whole

L. generally unspecified, inflammation

M. disease due to intoxication

N. disease due to electricity

O. new growths

Listing

Directions: List the items called for in each of the following. Select your answers carefully

1. Diseases were classified into four types known as the four humors by the early Greeks. These types are:

(A)____________________ Represents __________________

(B)____________________ Represents __________________

(C)____________________ Represents __________________

(D)____________________ Represents __________________

2. The Standard Nomenclature of Diseases and Pathological Conditions, Injuries, and Poisonings for the United States was an attempted consolidation of the following nomenclatures:

(A)____

(B)____

(C)____

(D)____

(E)____

(F)____

(G)____

3. The primary purposes of the standard Nomenclature of Diseases and Operations are:

(A)____

____

(B)____

____

(C)____

____

4. In the etiological classification of the standard Nomenclature, digits one through three denote or indicate the following, respe respectively:

   (A) ______________________________

   (B) ______________________________

   (C) ______________________________

5. Operation nomenclature follows the same scheme as the disease nomenclature and is based on two primary factors:

   (A) ______________________________

   (B) ______________________________

Assignment
Sheet No. 11

Covering
Units 65-72

INDEXING PROCEDURES

One of the major steps in making medical records readily available is to prepare four indexes: (1) disease index, (2) operation index, (3) physicians' index, and (4) patients index. Without proper indexes, it would be extremely difficult to find the records when they are needed for research or treatment of the patients.

There are different methods or systems used to compile the four indexes, and each hospital chooses the procedure which will best meet its particular needs. The medical record technician must be reasonably familiar with all acceptable indexing procedures and be thoroughly proficient with the particular indexing method(s) used in the hospital in which he works.

In this assignment you will have an opportunity to learn the various methods, systems and procedures for compiling and filing the four indexes.

Assignment:

1. Read the reference listed below.
2. Become thorouglly familiar with the indexing procedures used in the hospital in which you work. From your on-the-job experiences and the reference readings, write a short report (three to five pages) explaining the functions, advantages, and disadvantages of the particular indexes used in your hospital.
3. Answer the questions below and turn in this assignment by ______________________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 247-260, 315-340.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The first major step in processing medical records for research is to index them according to disease and operation.

T F 2. The filing of diseases and operations by code numbers affords a brief description of the disease or operation.

T F 3. Code numbers offer a fuller description of a disease or operation than its accepted title.

T F 4. It is not too practical for small hospitals to use the SNDO as it necessitates a very large index file.

T F 5. It is the responsibility of the medical record librarian to operate and maintain disease and operation indexes but he must never code the diagnoses himself.

T F 6. Operation and disease index cards should contain a maximum of abbreviated data to limit unnecessary consultations of the medical record.

T F 7. Disease and operation cards are cross-indexed for a patient who has two or more different diagnoses.

T F 8. Group indexing necessitates a larger index file than does simple indexing.

T F 9. The dual system of classifying diseases and operations is useful and efficient in both large and small hosptials.

T F 10. Dual grouping of diseases and operations is done by using the two-digit topographical SNDO code numbers for the index card titles.

T F 11. The complete topographical, etiology or procedure numbers are not posted anywhere on the index cards.

T F 12. A very important rule that must be followed when dual indexing is never to make out more than one index card for any one particular case.

T F 13. A non-group card is used in dual index grouping when a particular diagnoses occurs very frequently.

T F 14. The extent to which titles are added to the minimum code numbers suggested for dual group indexing is determined by the type of work done in the hospital.

T F 15. Indexing by the master code method is faster than the dual method.

T F 16. The dual method is replacing the master code method of' indexing.

T F 17. The master code method requires more experienced personnel for posting than does the dual method.

T F 18. When using the master code method, a specific case in the disease index should be grouped both topographically and etiologically on one card.

T F 19. Cases may be found faster with the dual method than with the master code methods.

T F 20. The use of two pyramids in the master code number increases the possibility of error.

T F 21. Grouping by both site and etiology on one card is permissible with the master code method.

T F 22. Incomplete code numbers are acceptable in the column portion of the group index card.

T F 23. When cross-indexing diseases and operations, each manifestation of a patient with multiple conditions is entered on a separate card which in turn refers to all the other conditions.

T F 24. Cross-indexing should not be done unless physicians frequently request information about combinations of diseases and/or operations.

T F 25. Cross-indexing of a single case many entail a large number of entries on three or more individual cards.

T F 26. Generally only the larger hospitals index supplementary manifestations or terms.

T F 27. Whenever supplementary terms are to be indexed, all conditions should be included on the master index list.

T F 28. Time may be saved by posting the procedure code on the disease index card when the site number is the same for both the disease and operation.

T F 29. Medical record librarians are justified in their contention that combinations of diagnoses cannot be pulled under the simple index methods.

T F 30. Most physicians' indexes are based on the SNDO and are arranged numerically on visible or verticle cards.

T F 31. Visible files that use the pocket type holder are not practical as too much time is spent removing the cards from them.

T F 32. Though some disease and operation diagnosis are shown out of numerical sequence in the SNDO, they are always filed in strict numerical order in the verticle file indexes.

T F 33. An annual arrangement of the patients' index file is preferred over a master file covering many years.

T F 34. The phonetic filing system is often used in communities having large populations with foreign names.

T F 35. In the phonetic system, the first letter of the surname furnishes the key letter from which all subsequent code numbers are derived.

T F 36. An advantage of the phonetic system is that all names that sound alike are grouped together in the file and can be quickly found.

T F 37. Diagnoses and operation code numbers are generally recorded on the patients index card.

T F 38. Plastic self-indexes are used to extend certain patient's index cards about 3/8" above the other cards and thus serve as guides.

T F 39. Mechanical files may be used for both MIB and the larger size patient's index cards.

T F 40. Usually number indexes, patients' registers, and admission discharge lists are permanently kept in loose-leaf binders.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. One of the primary reasons for keeping medical records is for _______________.
2. Usually the last step before indexing is for the _______________ to inspect and _______________ the medical record.
3. The medical record should be inspected before indexing to make sure it contains sufficient data to justify the _______________ and warrant the _______________ and end results.
4. Disease and operation indexes based on the SNDO are arranged _______________ according to the _______________ _______________.
5. Group indexing is a method whereby the cases that are related topographically, etiologically, or procedurally are grouped together under a _______________ _______________ number that embraces the _______________.
6. The only "results" of the care of the patient found on most index cards is the letters _______________ for _______________ and _______________ for _______________.
7. Grouping of indexes is done for a _______________ and _______________ of the indexes.
8. Dual group indexes contain more titles in the _______________ section than in the _______________ section of the file.

9. A medical record librarian must be well versed in knowledge of ______________ and the SNDO in order to utilize the master code indexing method.

10. Grouping by the master code number should be carried out to ________ digits and ________ pyramid.

11. Any method of group indexing requires the recording of the ______________ code number according to the SNDO on the ______________ ______________ of the medical record.

12. Each disease or operation code number should be checked off on the ______________ ______________ as indexing progresses.

13. A specific diagnosis for any one patient need be indexed only once per year regardless of the frequency of hospitalization if a ______________ record is maintained.

14. A specific diagnosis for any one patient must be indexed every time he is hospitalized during the year if a ______________ record is maintained.

15. A ______________ ______________ should be made before a decision is reached to undertake a cross-indexing program.

16. The work done and end results of treatment rendered by the medical staff is recorded on the ______________ index.

17. Disease and operation indexes are ______________ by drawing a double rule and recording the total entries for the year between the lines.

18. In visible files the ______________ ______________ and the ______________ of each card is always visible.

19. A ______________ file uses more space than a ______________ file.

20. Verticle files of disease and operation indexes usually use ______________ ______________ to assist the finding of data.

21. In a verticle file, the dual method cards are ______________ arranged according to the ________ digit ______________ code numbers.

22. The type of equipment used most often and least in cost for holding index cards are ______________ ______________ and ______________ ______________.

23. The key index for locating any particular ______________ ______________ is the patients' index.

24. The patients'index is kept as a ____________ file except some exceedingly large indexes are reduced by pulling cards of patients over 65 whose record has been inactive for a ________ year period.

25. In the phonetic filing system, all letters except the five vowels and the letters ________, ________, and ________ are reduced to ________ key letters which, in turn, have a corresponding numerical code.

26. In the phonetic filing system, the key letter for the equivalent "S" is ________ and its code number is ________.

27. It is claimed that phonetic filing detects ____________ of cards and discloses ________% of all transposition of letter errors.

28. Most small and medium size hospitals use patient's index cards ________ X ________ inches in size because they file them according to a ____________ or ________________ number.

29. A standard 8 drawer, triple-compartment file cabinet will hold approximately ________ average weight cards and guides.

30. Many large hospitals use the ____________ system of numbering for their patient's index and impairment cards which are ________ X ________ inches in size.

31. Assuming the file cards are actively used, mechanical or ____________files should be used for patient's indexes of more than ________ cards.

32. The number index is compiled from either the daily ____________ list or from the ____________ ____________ ____________.

33. The major function of a number index is to serve as a ____________ control.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The JCAH considers that medical records should be completed and ready for indexing within (A) 1 day; (B) 1 week; (C) 1 month; (D) 6 months; (E) 1 year.

_____ 2. In a disease code number, the part to the left of the hyphen indicates the (A) site of the illness; (B) causitive factor; (C) part which is operated upon; (D) operative procedure.

_____ 3. When indexing diseases and operations by the simple index method

______ 3. When indexing diseases and operations by the simple index method (A) one master card is made out for all closely related diagnoses entities; (B) a separate card is made out for each diagnose entity; (C) one card is made out for each patient even if he suffers from more than one entity; (D) a combination disease and operation card is used for each diagnosis entity.

______ 4. The simple indexing method usually results in (A) a larger file than the dual index method; (B) a smaller file than the dual index method; (C) the same size file as the dual index method; (D) a smaller file than the master code index method.

______ 5. The physicians' index is a requirement for accreditation by the JCAH of hospitals (A) with open staffs; (B) with closed staffs; (C) which use the dual index method; (D) which use the master code method; (E) which use the simple index method.

______ 6. The patients' index card is generally filled out by the (A) physician; (B) floor nurse; (C) medical record librarian; (D) admitting clerk.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. List the four indexes necessary in every medical record department in order to meet all requirements:

(A)______________________________ (C)______________________________

(B)______________________________ (D)______________________________

2. List the three methods of indexing diseases and operations:

(A)____

(B)____

(C)____

3. List the three advantages of dual grouping of diseases and operations:

(A)____

(B)____

(C)____

4. Physicians' index cards are usually subpeonaed only for the following two reasons:

(A)____

(B)____

____

5. List two advantages of visible files:

(A)____

(B)____

6. The two reasons a continuous file is more advantagous than an annual file are:

(A)____

(B)____

7. List two reasons why a verticle file is more advantagous than a bound book for filing patients index cards:

(A)____

(B)____

8. State the one great disadvantage of phonetic filing:

(A)____

____

Matching

Alphabetical Filing Techniques

Directions: The left hand column below is a list of names and phrases which call for special techniques when filing index cards in alphabetical order. The right hand column contains a list of procedures to follow. You are to match the procedures to the names and phrases by placing the letter of the procedure in the correct blank provided by the left hand column of items. Note that there are more procedures in the right hand column than there are names and phrases. There is only one correct answer for each left column item and the extra procedures are incorrect.

Names and Phrases

_____ 1. 2 cards for 1 patient

_____ 2. 2 patients with identical sur and given names

_____ 3. Names with prefixes

_____ 4. St.

_____ 5. Hyphenated names

_____ 6. Religious titles

_____ 7. Sister Mary Consuelo Hanrahan

_____ 8. Mac and Mc

_____ 9. Married women

_____ 10. Baer

_____ 11. One name in five begins with this letter

_____ 12. There are twice as many "B" names as there are names beginning with this letter

_____ 13. Names beginning with this letter are few

_____ 14. Female patient who got married since a previous admission

_____ 15. Spanish names

Procedures

A. Considered as part of the name

B. About 36 ways to spell the nam

C. Filed first by fathers surname and then mothers maiden name

D. Filed as one word

E. May be combined without distinction as to spelling

F. Arranged in chronological orde

G. Filed under religious name commonly used

H. About 10 ways to spell the nam

I. Disregarded

J. M

K. A

L. W

M. J

N. I

O. G

P. Alphabetically by legal and given name

Q. Filed alphabetically as though completely spelled out

R. Filed alphabetically by middle initial

S. Cross reference to previous surname

Assignment
Sheet No. 12

Covering
Units 73-78

THE I C D AND AUTOMATIC DATA PROCESSING

It is very important that the medical record librarian be familiar with the International Classification of Diseases (I C D). This manual and various modifications of the basic text are being increasingly used in our nation's hospitals for indexing purposes. Even if the hospital where you work does not use the I C D, you will find a knowledge of the basic manual useful in reading current and periodical literature pertinent to medical record technology.

The processing of data by electronic equipment and computers is vital to a modern up-to-date medical record department. It is a useful tool for both research and mundane record keeping. A person who desires to make medical record technology his career must keep abreast of the new and revolutionary innovations of automatic data processing.

In this unit you will learn the principles for using the I C D and its variations, the general aspects of automatic data processing and equipment, and the relationship of the I C D and other classification manuals to the various indexes as they are prepared by automated processing equipment.

Assignment:

1. Read the reference listed below.
2. In a two to three page paper compare the advantages and disadvantages of:
   A. the I C D as opposed to the SNDO
   B. the processing of data by manual methods and by automated equipment.
3. Answer the questions below and turn in this assignment by ______________________________.

References:

A. Huffman, Manual for Medical Record Librarians, pp. 341-352, 399-414.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The International Classification of Diseases is widely used as a disease index in the United States.

T F 2. The I C D has recently gained recognition because it has a simple coding system and it is continually revised.

T F 3. The letters I C D and I S C D refer to different editions of the same publication.

T F 4. Volume two of the I C D A is a tabular list of diseases and operations.

T F 5. The main disease classification section headings of Vol. I of I C D A are identical to those of Vol. I of I C D.

T F 6. The code numbers of the I C D A disease terms are directly related to the I C D A operation code numbers.

T F 7. Decimal digits may be added to the I C D A code numbers arbitrarily by the coder to amplify or permit greater detail.

T F 8. Diseases should be looked up in the I C D A index under the site rather than the condition.

T F 9. Diagnoses suspected on admission which are later ruled out before discharge of the patient are always coded except for pregnancy examinations.

T F 10. A symptom code is general and implies that a definite diagnosis has been made.

T F 11. The letter N of the I C A injury code numbers has been eliminated in the I C D A.

T F 12. A disease index may be set up by using the main headings of the classifications found in Vol. I of the I C D A as guides.

T F 13. The I C D A cannot be used for operation indexing.

T F 14. The I C D and I C D A are classifications and nomenclatures of diseases and operations.

T F 15. The functions of a medical record librarian may be described as the handling of information about hospital patients.

T F 16. Automatic data processing has increased rapidly because of the complexity of information needed in modern medical care, research, education and administration.

T F 17. The author discusses automatic data processing in a highly technical manner because of the complex nature of automatic processing.

T F 18. Though there are model changes every year, the basic methods of automatic data processing always remain the same.

T F 19. Automatic data processing will not decrease the need for medical record librarians but will displace medical record technicians.

T F 20. The use of punched or perforated cards dates to the late 1700's when they were used on machinery.

T F 21. The Powers method of data processing was invented before the electrical method presently sold by I B M.

T F 22. Electronic computers were first used for scientific purposes in 1947.

T F 23. The medical profession was one of the first fields to recognize the great possibilities of automatic data processing equipment.

T F 24. The term automatic data processing is correctly applied only to electronically activated machines.

T F 25. Although an adding machine is considered a computer, modern usage of the word general connotes an electronic computer.

T F 26. Electronic computers can solve problems which are so mathematically complex that they cannot be solved manually by man.

T F 27. A chief asset of electronic computers which is highly important to medical record librarians is that they can quickly store and retrieve huge masses of data such as medical records.

T F 28. Electronic computers can be used only to perform statistical and mathematical computations.

T F 29. Digital computers accept only numerical input.

T F 30. The punched cards used with computers have been standardized to one basic size, shape and hole location.

T F 31. A disadvantage of automatic data processing is that indexes and reports are not continually up-to-date and the summary sheets cannot be prepared until all patients' records have been completed for the designated time period.

T F 32. Automated daily census reports are cumulative to form the bulk of the usual monthly report to the medical and administrative staffs.

T F 33. Many hospitals maintain separate files of punched cards for medical and census information because they do not have a computer suitable for providing easy access to grouped information.

T F 34. Punched cards containing medical information serve as disease and operation indexes.

T F 35. Hospitals using punched cards for medical information generally prefer the I C D rather than the S N D O for obtaining code numbers.

T F 36. All the necessary medical data of each patient must be contained on one punched card when the latter are used as input to computers.

T F 37. If a patient has three diagnoses punched on his card, two duplicate cards must be punched to maintain the original form of filing order.

T F 38. Duplicate medical punched cards are usually produced by key punch operations copying from the original medical record.

T F 39. Automatic maintenance of indexes requires electronic computers and other elaborate processing equipment.

T F 40. The financial, business and medical record departments should have separate data processing centers as their report data requirements are entirely different in nature and do not overlap.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. The Manual of the International List of Causes of Death was designed to aid in securing uniformity in ________________ ________________.

2. Three early leaders who set the foundation in the 17th and 18th centuries for the development of the present I C D were Captain John ________________, William ________________ and Florence ________________.

3. One of the first drafts of a classification for international use was presented by Dr. Jacques ________________ to the International Statistical Institute in ________.

4. The sixth and current revisions of the I C D have been made by the ____________________ ____________________ ____________________.

5. Volume I of the I S C D is a listing of the ________________ of ________________ and the second is an ________________ index of these listings.

6. Non-fatal diseases were not included in the I S C D until the ________________ revision (1948).

7. The usefulness of a modified version of the I S C D for hospital indexing purposes was proven by a research pilot study done in ________ by the American Hospital Association and American Association of ______________ ______________ ______________.

8. The pilot study referred to in question 7 resulted in P. H. S. #719, commonly referred to as ______________, first published in ________ and revised in ________.

9. The basic number of digits for I C D A disease conditions is ________ and operative procedures are assigned ________ digits.

10. Birth code numbers in the I C D A are preceded by the letter ________.

11. Obstetrical conditions in the I C D A are divided into ________ groups with the first two code digits ________ being common to all groups.

12. When using the I C D A for indexing, the headings and subheadings are filed in strict ______________ sequence.

13. The I C D A is a ______________ tool for people who maintain and post medical data to indexes.

14. The term data processing is practically synonymous with the phrase ______________ ______________ ______________.

15. The man who linked electricity and punched cards to invent electrical tabulating equipment was Dr. ______________ ______________.

16. The first use of automatic tabulation equipment was to process the ________ U. S. population census.

17. The early Powers method of automatic data processing used a ______________ system and is now marketed by ______________ ______________ Company

18. The big breakthrough in the use of computers for business operations was the development of the inexpensive ______________ in ________.

19. The two types of electronic computers are the ______________ and ______________.

20. The most common way by which man communicates with electronic computers is through ______________ ______________.

21. Systems and equipment used to store and retrieve miniaturized images of original documents, such as medical records, are called ______________ ______________.

22. Because modern computer equipment is very expensive, it is generally believed that hospitals will resort to ______________ ______________ computer centers.

23. P A S, which stands for ______________ ______________ ______________, was started in ________ to provide ______________ summaries so that the participating hospitals could evaluate the care provided to the patients.

24. Participating P A S hospitals prepare a ________ page abstract of the medical report with the diagnoses and operations coded to an adaptation of the ______________.

25. The nation-wide program dedicated to reducing pregnancy wastage is called the ______________ ______________ which utilizes a code sheet filled out according to the ______________.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. List the uses of the I C D in the order of their importance.

(A)______________________________

(B)______________________________

2. List four advantages of automatic data processing over manual methods.

(A)______________ (C)______________

(B)______________ (D)______________

3. List the four major components of an electronic computer.

(A)______________________________

(B)______________________________

(C)______________________________

(D)______________________________

4. List the manual postings which are eliminated in P A S hospitals.

(A)______________________________

(B)______________________________

(C)______________________________

(D)______________________________

5. List the monthly reports received by P A S hospitals from the data processing center.

(A)______________________________

(B)______________________________

(C)______________________________

(D)______________________________

(E)______________________________

6. List the indexes which P A S hospitals receive every 6 months.

(A)_______________ (C)_______________

(B)_______________ (D)_______________

7. List the summaries which P A S hospitals receive every 6 months.

(A)_______________ (C)_______________

(B)_______________ (D)_______________

8. List the three sets of tabulations sent to hospitals which participate in the nation-wide maternity and newborn project.

(A)______________________________

(B)______________________________

(C)______________________________

9. What daily lists are made available when the daily census is automated?

(A) 1. ____________________________

2. ____________________________

(B) 1. ____________________________

2. ____________________________

Assignment
Sheet No. 13

Covering
Units 79-83

STATISTICAL DATA

The statistical reporting of professional work performed in hospitals is considered very important. It should be done with extreme care and accuracy, and in a systematic manner.

Statistics deal with the frequency of occurrence of things. Statistics give convincing proof of the importance of medicine and its practice by professional people. The data collected for statistical reports by the medical record department deal with vital statistics and medical statistics.

In this assignment you will have an opportunity to become familiar with the importance as well as the collection and recording of data essential for statistical reporting.

Assignment:

1. Read the reference listed below.
2. Answer the questions below and turn in this assignment by ______________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 353-371.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. Statistical reports are valuable in attaining accreditation but are of limited value in evaluating professional performance of the medical staff.

T F 2. The medical record technician is not only responsible for the gathering of statistical data but also for its interpretation.

T F 3. Proof of identity necessary in inheritance claims may be obtained from birth registration records.

T F 4. Death registration certificates in some instances provide information for sickness insurance claims.

T F 5. Currently the majority of states have revised their death and birth certificates to conform to the U. S. standard certificates.

T F 6. If an additional record of information from the death certificate is desired, this information should be copied into the Register of Deaths.

T F 7. A Register of Births is required by law in very few states.

T F 8. The Register of Births contains information concerning only the newborn child.

T F 9. The Register of Deaths contains information concerning the causes of death of the deceased.

T F 10. Data concerning fetal deaths may be entered in chronological order with the live births in the Register of Births.

T F 11. Certificates of births are becoming more standardized throughout the United States.

T F 12. The term "stillbirth" is no longer used in international tables.

T F 13. Illegitimate births and the laws governing them are of no consequence to the medical record librarians.

T F 14. Under the new terminology, an immature infant is one whose weight is 5 3/4 pounds or less.

T F 15. In the United States information such as marriage, divorce, and death of a person is sent back to the state which issued the birth number and is posted against the birth record.

T F 16. Many of the states now print code numbers on the birth certificates patterened after the new numbering of birth certificate systems.

T F 17. It is the responsibility of the medical record personnel to assign a code number for placement on the birth certificate prior to sending information to the state health agency.

T F 18. It is sometimes true that certain information that is being reported out of the medical record department is no longer required.

T F 19. A report that is easy to prepare is generally the most accurate.

T F 20. The daily cumulative tabulation of data will provide the most accurate reports.

T F 21. The analysis of hospital service is intended to give a picture of the type of illnesses cared for by the hospital and their end results.

T F 22. All hospitals of 75 or more beds must have a newborn service if it is to be accredited by the J C A H.

T F 23. The posting from the medical records of the discharged to the daily analysis of hospital service work sheet should be done daily.

T F 24. The hospital number is not posted on the daily analysis of hospital service work sheet.

T F 25. The column headed "Special Statistics" on the daily analysis of hospital service form may be used for classification of other data for which definite space has not been provided.

T F 26. The name of the attending physician is always essential and is, therefore, required on the daily analysis of hospital service sheets.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. Statistics may be thought of as dealing with facts which are represented by ______________.

2. Statistical methods should be reviewed ______________.

3. Statistical data is accurate only if the source is accurate, which for medical statistics is from the ______________ ______________.

4. The responsibility for the actual reporting of birth and death certificates rests with the ______________ or the ______________

5. The ______________ ______________ or the stub of birth and death certificates should become a part of the medical record.

6. To arrive at more uniformly accepted definitions of fetal deaths and premature infants a study or terminology was made by the Committee on ______________ ______________.

7. A death of a product of conception prior to complete expulsion or extraction from the mother is called a ______________ death (the new term).

8. Under the newer terminology, live births have been grouped into four categories, two under ______________ ______________ and two under ______________ ______________.

9. In Canada a birth number has been assigned to every living person born since ________.

10. The Annual Survey of Hospitals Accepted for Registration report form is distributed by the ______________ ______________ ______________.

11. The form for approving internships and residencies is distributed by the Council on Medical Education and Hospitals of the ______________ ______________ ______________.

12. The ______________ of data is the first step in preparing any statistical report.

13. In order that statistics may be comparable among hospitals the ______________ ______________ of Hospital Service work should be made out.

14. A true picture of the work of the hospital can be attained only from the ______________ ______________ and the results on discharge.

15. The three basic departments that a hospital of 75 beds should have are ______________, ______________, and ______________.

16. Each case entered in the daily analysis of hospital service sheet should be listed under only one service according to the ______________ ______________ for hospitalization.

17. Only ______________ consultation reports should be counted in the daily analysis of hospital service form.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. The responsibility for the statistical content of reports belongs to the (A) physician; (B) nurse; (C) admitting officer; (D) medical record librarian.

_____ 2. The older term, "abortion," is now classified as a fetal death under group (A) I; (B) II; (C) III; (D) IV.

_____ 3. The first digit of the first number of the new system of numbering birth certificates stands for (A) year of birth; (B) born in the United States; (C) indicates state in which born; (D) indicates sequence of birth.

_____ 4. All of the following conditions are reported in the "not delivered" section of obstetrics except for (A) lactating breasts; (B) false labors; (C) aborted infants; (D) retained placentas.

Matching

Directions: In the left hand column is a list of services as used in the Daily Analysis of Hospital Service. The right hand column contains the definitions of these services. Match the meaning of the service to the appropriate service by placing the letter of the definition in the blank at the left of the service.

_____ 1. medicine

_____ 2. opthalmology

_____ 3. thoracic surgery

_____ 4. allergy

_____ 5. gynecology

_____ 6. otorhinolarngology

_____ 7. communicable disease

_____ 8. dermatology

_____ 9. psychiatry

_____ 10. plastic surgery

A. includes cases having a condition due to hypersensitivity to specific allergens

B. includes diseases and conditions of the female generative and urinary organs

C. includes all cases of mental disorders

D. includes all diseases and conditions treated by the administration of internal remedies except those assigned to a subspecialty

E. includes all transmissible diseases in the customary acceptance of the term

F. includes cases of surgery concerned with repair for the restoration of deformed or mutilated parts of the body

G. includes diseases, injuries, and conditions of the eye

H. includes all diseases of the ear, nose, throat, larynx, pharynx, nasopharynx, and tracheobronchial tree

I. includes all diseases of the chest in which surgery of any type is performed

J. includes all diseases and conditions of the skin

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. List the requirements for statistics and reports if they are to be of value in measuring performance:

(A) ______________________ (D) ______________________

(B) ______________________ (E) ______________________

(C) ______________________

2. The two kinds of basic data to be collected for use for statistical reports and which are determined by the reports to be made are:

(A) ____

____

(B) ____

____

Assignment
Sheet No. 14

Covering
Units 84-88

STATISTICAL DATA AND REPORTS

As one becomes more familiar with the data collected for statistical reporting, you realize that much of the various data compiled is the responsibility of other departments. However, in many cases it will be your duty to compile data of a specialized type.

The medical record technician can perform an invaluable service to the hospital and staff by providing valuable information, secured through an analysis of statistical data, for comparative reports of professional performance.

In this assignment you will have an opportunity to become familiar with the types of specialized reports, the computation of the reports, and the data needed for these reports.

Assignment:

1. Read the reference listed below.
2. Answer the questions below and turn in this assignment by ____________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 371-398.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The monthly analysis of hospital service includes all the data needed for the questionnaire sent to the hospital just prior to the survey of the Joint Commission on Accreditation of Hospitals.

T F 2. The comparative report, though useful to the medical staff, is not required for accreditation purposes by the JCAH.

T F 3. In compiling an analysis of hospital service reports, both discharged patients and patients remaining should be included.

T F 4. The institutional infections must be allocated to the services before the monthly analysis of hospital service is complete.

T F 5. The medical record technician should not attempt to make the allocations for institutional infections.

T F 6. The questionnaire used for approving internships and/or residencies requires the arrangement of data according to the S N D O.

T F 7. Annual reports should be cummulated monthly rather than left for compiling all the monthly reports at one time at the year's end.

T F 8. Deaths occurring in the hospital ambulance or in the emergency room of the hospital should be included when computing the hospital death rate.

T F 9. An obstetrical patient who dies in the hospital before delivery is classified as a maternal death.

T F 10. The neonatal death rate refers to deaths of infants occurring within 36 days after live birth.

T F 11. Studies of infections occurring in the hospital are primarily concerned with determining which member of the medical staff committed an error.

T F 12. Medical record technicians frequently must determine whether an infection is a hospital or non-hospital infection.

T F 13. An infection of an accidental wound occurring outside the hospital is never considered as a postoperative infection.

T F 14. The net morbidity rate is the ratio of all infections in clean surgical cases to the number of operations.

T F 15. Abortions (infants with a gestation period of less than 20 weeks) are not included when computing the stillbirth fatal death rate.

T F 16. Autopsies on stillbirths are included in figuring the autopsy rate.

T F 17. Cases dead on arrival (DOA) are not included in figuring the autopsy percentages of the hospital.

T F 18. In computing the length of stay, the day of discharge is not counted if the patient has been in the hospital the perceding day.

T F 19. Newborns are not included when computing the average length of stay.

T F 20. The census count should be taken only at 24-hour intervals.

T F 21. The census count is usually taken at midnight because there are fewer admissions and discharges at this time.

T F 22. Newborn-days' care must be included when computing the average daily census.

T F 23. The maximum patient-days' care is computed my multiplying the number of days in the month by the number of adult beds available in the hospital

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. When making an analysis of hospital service reports, only those patients who have been ______________ or have ______________ will be included.

2. Percentages are generally not calculated on a base of less than ________.

3. A hospital had a total of 40 deaths during the month of June. These included all deaths of inpatients of all ages, both over and under 48 hours, as well as coroner's or medical examiner's cases. During this same period the hospital discharged a total of 800 inpatients (including deaths). The gross death rate in this hospital is ______________ for the month of June.

4. Postoperative deaths are regarded as deaths that occur within the first ________ days following the operation according to the Joint Commission on Accreditation of Hospitals.

5. During the month of October a hospital had 4 postoperative deaths within the first ten days postoperative. The hospital also had 2 deaths that occurred after the convalescence period. All of these deaths occurred after a total of 2,000 operations. The postoperative death rate of this hospital is ________ for the month of October.

6. The basis for the computation of obstetrical morbidity generally is a temperature of ____________ occurring on any two of the first ____________ days postpartum.

7. A hospital had 30 deaths during the month of September, of which 8 were coroner's cases. Fifteen autopsies were performed on these 30 cases. Only four of the coroner's cases were autopsied. What is the gross autopsy rate? ____________. The net autopsy rate? ____________.

8. The minimum net autopsy rate required for approval for internship and residencies by the American Medical Association is ________ per cent.

9. The number of inpatients occupying hospital beds at any given time is called the ________________.

10. A patient is admitted and discharged the same day. The period of stay should be counted as ________ patient-day.

Matching

Directions: In the left hand column is a list of the various percentages or rates which the medical record technician is generally required to compute. The right hand column contains the formulas for these computations. Match the percentage or rate to the appropriate formula by placing the letter of the formula in the blank at the left of each rate.

_____ 1. net death rate

_____ 2. maternal death rate

_____ 3. neonatal death rate

_____ 4. gross morbidity rate

_____ 5. net autopsy rate

A. $$\frac{\text{total autopsies for a given period x 100}}{\text{total deaths for a given period}}$$

B. $$\frac{\text{total number of infections for period x 100}}{\text{total number of patients dischared (including deaths) during period}}$$

C. $$\frac{\text{total number of infant deaths occurring within 28 days of birth for a given period x 100}}{\text{total number of newborn infants discharged (including deaths) during the period}}$$

D. $$\frac{\text{number of autopsies for a period x 100}}{\text{total number of deaths minus unautopsied coroner's or medical examiner's cases}}$$

E. $$\frac{\text{total number of deaths of obstetrical patients for period x 100}}{\text{total number of discharges (and deaths) of obstetrical patients for period}}$$

F. $$\frac{\text{total number of deaths for period x 100}}{\text{total number of discharges (and deaths) for the period}}$$

G. $$\frac{\text{total deaths 48 hours or over for period x 100}}{\text{total deaths over 48 hours and discharges for period}}$$

H. $$\frac{\text{total number of infections debited against the hospital for a given period x 100}}{\text{total number of patients discharged (including deaths) for that period}}$$

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. The information recorded about the patient upon the admission register includes:

(A) ______________________ (D) ______________________

(B) ______________________ (E) ______________________

(C) ______________________

Assignment
Sheet No. 15

Covering
Units 89-93

LEGAL ASPECTS OF MEDICAL RECORDS

The status and custody of hospital records as evidence in a court of law have long been a most perplexing question for the novice medical record technician. Laws may vary from state to state and consequently you should be familiar with the laws of your own particular state. The relationship between medicine and law has become part of the instruction in our law and medical schools of today. As the use of medical evidence in the courts is on the increase, it is important for you as a medical record technician to understand your legal responsibilities as far as the medical records are concerned.

In this assignment you will have an opportunity to learn some of the legal aspects of medical records, procedures for releasing medical records, and what information may or may not be released from the medical records.

Assignment:

1. Read the reference listed below.
2. Become thoroughly familiar with the state laws of your state and how they apply to medical records. From your observations summarize the laws in your state that apply to medical records in a short paper not to exceed three pages.

3. Answer the questions below and turn in this assignment by ____________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 415-456.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. Mediocolegal science is a relatively new development in the professions of law and medicine.

T F 2. Medical records are compiled primarily for the benefit of the patient.

T F 3. The patient always has the right to inspect his medical record, if he wishes to do so.

T F 4. It is in the best interest of the patient to be allowed to see his medical record if he so desires.

T F 5. If the attorney for a patient presents a written authorization from the patient requesting information about his client's medical record, the hospital is legally bound to release this information.

T F 6. The statutes concerning the relationship between the patient and physician are quite uniform throughout the country.

T F 7. If a patient waived the claim of privilege upon his medical record, it may be brought into court without a supoena.

T F 8. The claim of privilege is waived if a patient introduces his hospital record in evidence.

T F 9. Hospitals that use mechanically recorded data for medical records and have the data processed by commercial firms, are violating the privileged character of the medical record.

T F 10. Medical records or parts of medical records should never leave the hospital except in response to a court subpoena.

T F 11. The subpoena duces tecum is the type of subpoena generally served on a hospital to produce a record in court.

T F 12. If a hospital is served with a notary subpoena, the records requested should be taken to the court specified in the subpoena.

T F 13. All documents and records received in court for use as evidence must be properly authenticated.

T F 14. Subpoenas should be delivered by the server 24 hours in advance of the court case.

T F 15. Microfilms of medical records may be left in court if they are properly subpoenaed.

T F 16. The current trend is for states to greatly extend immunity from liability to hospitals.

T F 17. When a patient is admitted, the hospital then enters into an implied contract to render the necessary care and treatment services to that patient.

T F 18. Entries on the medical record that have been erased should be initialed and signed according to the rules of the hospital.

T F 19. Correspondence, etc., are considered an integral part of the medical record.

T F 20. Before you go on the witness stand, you should make yourself thoroughly familiar with all the facts upon which you are to testify.

T F 21. The presiding judge determines whether the hospital record shall be received in evidence.

T F 22. Though not legally required, it is a good practice to have the consent or authorization for release of information witnessed or notarized.

T F 23. The court may retain the medical record for an indefinite period.

T F 24. Great care should be taken not to release medical record information without the authorization of the patient or the responsible relative.

T F 25. Medical records should be returned to the hospital just as soon as possible after the court is through with them.

T F 26. Microfilmed records constitute secondary evidence.

T F 27. The medical record technician, upon receipt of a subpoena, should notify the attorney if the record requested is on film.

T F 28. It is the responsibility of the hospital for providing a means of reading a microfilmed medical record in court.

T F 29. The medical record technician should not allow a microfilm roll of medical records to leave his possession.

T F 30. Photographic prints are usually made of microfilmed records and after proper verification are used in lieu of the original film.

T F 31. Upon completion of written authorization giving consent to release a medical record, the written consent becomes a part of the medical record.

T F 32. A medical record technician may release confidential information if it is in the best interests of the patient.

T F 33. If a state or federal agency requests information from a medical record as a personal document, it may legally secure this information without a subpoena if written authorization is secured from the patient.

T F 34. The American Hospital Association and the Health Insurance Council have jointly developed a standard hospital insurance report for authorizing and releasing information to third party payors.

T F 35. A Blue Cross or Blue Shield membership card implies that the patient has authorized the necessary release of information from any hospital record.

T F 36. The administrator of each hospital should adopt definite regulations governing the release of information from the medical records.

T F 37. Information contained in the personal and statistical data of a medical record should never be altered.

T F 38. The initials of an authorized person on a medical record constitute a legal signature in the eyes of the court.

T F 39. An authorization for surgery is generally found on the back of the summary sheet and is usually signed by the patient when he is admitted.

T F 40. Oral consent to an operation is considered valid.

T F 41. In cases of emergency, a physician or surgeon is permitted to operate without the consent of the patient.

T F 42. An authorization for autopsy should be in writing.

T F 43. It is possible in some states for a patient to authorize an autopsy on his own body.

T F 44. Case summaries or abstracts should always be made out by the physician, never the medical record librarians.

T F 45. It is an accepted policy that doctors should not give authorization to insurance companies to secure medical records.

T F 46. The medical record librarian can refuse the resident and attending medical staff access to medical records if there is suspicion that the consultation is detrimental to the hospital or patient.

T F 47. The payment of hospitalization charges for an employee by an employer automatically gives the employer access to the medical record.

T F 48. The lien laws of all the states require the patient's authorization before the defendants in the damage suit may have access to the medical record.

T F 49. Surgery authorizations must be witnessed in order for them to be considered as legal documents.

T F 50. In some states, a married minor or a pregnant minor may validly authorize surgery for either themselves or their offspring.

T F 51. Surgery authorizations should show the time, as well as the date, when it was signed by the patient.

T F 52. According to Hayt, Hayt, and Groeschel, a minor who marries without parental consent is not emancipated and therefore cannot authorize surgery.

T F 53. Some states during the 1950's enacted laws which prohibit the subpoenaing of the records of committees which are seeking to improve the medical care in hospitals.

T F 54. It is questionable whether the records and reports of medical audit or tissue committees can be admitted as court evidence.

T F 55. A burn from a hot water bottle is classified as an incident.

T F 56. A report of an incident should never become a part of the patient's medical record.

T F 57. Incidents which involve visitors and other third parties should not be recorded.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. Medical records are the property of the ______________.
2. The confidential data within the medical record are considered the property of the ______________.
3. The hospital is compelled to produce its records by the serving of a ______________.
4. Certain private information given by a patient to his physician is considered ______________ ______________.
5. Medical records appear in court for cases concerned with ______________ ______________ ______________ more often than for all other types of cases combined.
6. A medical record technician is not obligated to present the medical record in court except upon a ______________ ______________ or ______________.
7. The power of subpoena in all states or territories of the United States rests with the ______________.
8. On the witness stand your attitude should be ______________ and ______________.
9. Proof of death certificates are signed by either the ______________ ______________ ______________ or the ______________

10. Fees are generally charged for medical record abstracts except to the ______________ ______________, social services bureaus, and hospital attorneys.

11. Standardized hospitalization forms should be used for all cases except for ______________ ______________ and ______________ ______________.

12. To be legally valid, an authorization for an operation to be performed should be an ______________ ______________.

13. Because of the increasing number of malpractice claims, authorizations for surgery should be obtained to protect the hospital, ______________, and ______________.

14. An authorization for autopsy is not necessary in ______________ or ______________ ______________ cases.

15. Accidents or incidents in the hospital are recorded as an ______________ ______________.

16. The American Hospital Association defines an incident as any ______________ which is not ______________ with the routine operation of the hospital or the routine care of a patient.

17. An incident must be recorded in the physician's ______________ ______________ and by the nurse in the nurses' notes.

Multiple-Choice

Directions: In the space at the left of each statement, write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. A government agency wishes to secure a medical record with the patient's consent from a hospital. It must (A) file a lien; (B) obtain a subpoena; (C) request a waiver; (D) obtain a judicial notice.

_____ 2. A request for an abstract of a medical record does not have to be authorized by the patient if (A) the patient requests it to be sent to a previous physician; (B) requested by the patient's new physician; (C) requested by the attending physician; (D) the patient requests it to be sent to his new physician.

_____ 3. A man is the sole surviving member of his family. His first wife and both of their children are dead. He has remarried but is divorced. His father and brother are living. Upon his death the hospital wishes to perform an autopsy. To get an authorization for an autopsy you must secure the approval of (A) his former wife; (B) his brother (C) his father; (D) his physician.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. Medical records are generally used in the following court cases:

   (A) ____________________ (D) ____________________

   (B) ____________________ (E) ____________________

   (C) ____________________ (F) ____________________

2. Medical records have been used in many types of criminal cases. They are:

   (A) ____________________ (D) ____________________

   (B) ____________________ (E) ____________________

   (C) ____________________ (F) ____________________

3. Before taking the medical record from the hospital you should:

   (A) ____

   (B) ____

   (C) ____

   (D) ____

   (E) ____

   (F) ____

4. If a physician wishes to change information on a medical record, he should make a note and attach it to the medical record. This note should contain:

   (A) ____________________ (C) ____________________

   (B) ____________________ (D) ____________________

5. Occasionally mistakes are made in writing records; the procedure for correcting a mistake would be to:

   (A) ____.

   (B) ____

   (C) ____

   (D) ____

Assignment
Sheet No. 16

Covering
Units 94-102

INTERDEPARTMENTAL RELATIONS

As a medical record technician you will come into contact with innumerable members of the hospital staff and other service members of the hospital. This relationship between departments should be cooperative and harmonious. To accomplish this ideal of cooperation, you need to know something about your responsibilities to other departments and their responsibilities to the medical records department.

The cooperation needed to efficiently operate a hospital depends upon its function. If every department and individual in the hospital would remember that the primary function of the hospital is to provide the proper care for the injured and sick, then the task of interdepartmental relations would be much less complicated.

In many hospitals the medical record librarian must double as a medical reference librarian. This is especially true in small hospitals. Because of this fact, the medical record librarian should have a basic understanding of library methods and procedures.

In this assignment you will have an opportunity to learn some of the responsibilities of other departments, your relationships with them, and some of the duties of the medical librarian.

Assignment:

1. Read the reference listed below.
2. Make a list of the departments you have contacted in your present job and with the help of the medical record librariai determine what departments have been a cause of concern to the medical record department. In a two- or three-page paper give your suggestions for improving the relationship between the medical record department and these other departments.
3. Answer the questions below and turn in this assignment by ________________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 497-508, 549-562.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The medical record librarian should maintain direct or liaison relationships with every department in the hospital

T F 2. A knowledge of fundamental principles of personnel administration is not necessary for the medical record technician.

T F 3. The medical record technician must remember that his department is just one part of the hospital.

T F 4. In order to promote coöperation between various departments in the hospital mutual understanding is necessary.

T F 5. The medical record technician will have no direct contact with the governing body of the hospital.

T F 6. It is the duty of the medical record committee to see that accurate and complete medical records are secured for every patient treated.

T F 7. A poor relationship between the medical staff and the medical record librarian is usually the fault of the librarian.

T F 8. Medical records are not indexed until they are complete.

T F 9. It would be foolish for the medical record technician to attempt to orient fellows, residents, interns, or clerks, to the value and purposes of medical records.

T F 10. The medical record technician should attempt to talk to student nurses and the nursing staff and explain the functions of the medical record department.

T F 11. The diverse circumstances under which the medical record librarian and the admitting officer work can produce friction between them.

T F 12. Clinical and pathological reports are very valuable to the physician in diagnosis and treatment.

T F 13. There are certain laboratory records which will not be sent to the record department until a patient is discharged.

T F 14. In cases where a special diet is necessary, it should be entered on the patient's record and become part of the medical record.

T F 15. In making out an author card for the dictionary card catalog, if a book has more than one author, you should make an author card for each author.

T F 16. It is possible to order printed author cards from the Library of Congress.

T F 17. A title card has the author's name listed above the title of the book.

T F 18. A subject card has the classification number of the book above the author's name.

T F 19. When making a subject card, it is desirable to use a standard list of subject headings.

T F 20. A shelf list is a catalog of the books in the order in which they appear on the shelves.

T F 21. A separate card index should be made for journals and periodicals.

T F 22. The first comprehensive index on medical literature was the Current List of Medical Literature, published in 1872.

T F 23. The medical librarian should be informed about the Inter-Library Loan Code and various sources from which he may secure library book loans.

T F 24. Many hospitals combine the functions of the medical library with those of the medical record department.

T F 25. Very rarely does the medical record librarian have interdepartmental contacts with the accounting or stores departments.

T F 26. Because of the nature of maintenance work, the medical record department has no contact with the maintenance crew.

T F 27. Hospitals without libraries cannot receive J C A H accreditation.

T F 28. The "Supplement of the Standards" of the J C A H requires hospitals to have a specific number of books in certain medical catagories in order to receive accreditation.

T F 29. The method used to charge out medical records can be easily modified and used for charging out books.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. In describing good interdepartmental relations, A. H. Scheidt likened a hospital to a ______________ ______________.

2. An essential characteristic in dealing with people is ______________ and, according to Teal and Metcalf, it is born of a regard for the personality of others.

3. The liason link between the medical record department and the medical staff is the ______________ ______________ ______________.

4. The medical record librarian must contact the roentgenologist in in the rare instance when the latter's ______________ ______________ has not reached the medical record by the discharge time of the patient.

5. Clinical recording done by the nurse requires ____________, ____________ in reporting developments, and careful ____________ of services performed.

6. The original source of the sociological data in the medical record is secured from the ____________ department.

7. The anesthetist's record must show, among other things, the ____________, ____________ and ____________ at regular intervals, together with an estimate of the ____________ of the patient at the end of the operation.

8. The proper care of the sick and injured should be the ____________ ____________ of all hospitals and people employed in them.

9. One of the first things to decide upon when organizing a medium or large medical reference library is a ____________ of ____________.

10. A book containing a record of all volumes in the library in the order of their receipt, together with a statement of the cost and source of supply for each, is called the ____________ ____________.

11. Lettering on the spine of the book should be covered with ____________.

12. The key to the resources of the library is the ____________ ____________ ____________.

13. All journals which are to be retained permanently should be ____________, and this is the responsibility of the ____________.

14. The number found immediately below the classification number on an author card is the ____________ ____________ which is found in the book ____________ ____________ ____________ written by Charles A. Cutter.

15. The two comprehensive indexes to medical literature currently in use (since 1960) are the ____________ ____________ prepared ____________ by the National Library of Medicine and the ____________ ____________ ____________ prepared ____________ by the A M A.

16. An individual who wishes to consult a comprehensive index for the period 1950-1960 would have to use the ____________ ____________ ____________ ____________ ____________ and the ____________ ____________ ____________ ____________.

17. The A M A has a ____________ by subject and many complete current journals available on inter-library loan. A similar service is offered by the Library of the American College of Surgeons in the areas of ____________ and ____________ ____________.

18. A microfilm and photostat inter-library loan service is available from the ______________ ______________ ______________ ______________

19. The Bacon Library of the American Hospital Association has a ______________ library inter-library loan service covering the ______________ and ______________ fields.

20. Cushing notes that "the soul of an institution that has any pretense to learning comes to reside in its ______________."

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. The medical record technician must maintain contact with various departments of the hospital. Ten of these departments discussed in your text are:

(A) ______________________________

(B) ______________________________

(C) ______________________________

(D) ______________________________

(E) ______________________________

(F) ______________________________

(G) ______________________________

(H) ______________________________

(I) ______________________________

(J) ______________________________

(K) ______________________________

(L) ______________________________

(M) ______________________________

(N) ______________________________

2. Records are many times used in medical staff meetings for:

(A) ______________________________

(B) ______________________________

(C) ______________________________

(D) ______________________________

3. The most common systems of classification used for medical reference materials are:

(A) ______________________________

(B) ______________________________

(C) ______________________________

(D) ______________________________

(E) ______________________________

4. As books are acquired by the medical library, certain procedures should be followed in processing them. In order, they are:

(A) ______________________________

(B) ______________________________

(C) ______________________________

(D) ______________________________

5. The listings in the dictionary card catalog are listed alphabetically by:

(A) ________________ (C) ________________

(B) ________________

Assignment
Sheet No. 17

Covering
Units 103-110

ORGANIZATION, MANAGEMENT, AND SUPERVISION OF THE MEDICAL RECORD DEPARTMENT

The management of the medical record department is the responsibility of the medical record librarian. As head of his department he exercises a high degree of independence in its administration. He must be capable of organizing an efficient and smooth-running department.

As a medical record technician you will be delegated certain supervisory and managerial duties. Therefore, it is important that you understand the functions of organization, management, and supervision as applied to the medical records department.

In this assignment you will have an opportunity to become familiar with the types of organization, flow and control of work, departmental equipment, and planning procedures for laying out medical records departments.

Assignment:

1. Read the reference listed below.
2. Determine the type of organization you have at your place of employment and make an organizational chart for your hospital.
3. Make a sketch of the medical records department in your place of employment, and consult with the medical record librarian as to what features could be improved.
4. Answer the questions below and turn in this assignment by ________________.

Reference:

A. Huffman, Manual for Medical Record Librarians, pp. 457-496.

Questions:

True-False

Directions: The following statements are either true or false. If the statement is true, draw a circle around the letter "T." If it is false, draw a circle around the letter "F."

T F 1. The type of organization adopted for an institution must fit the institution and its main purposes.

T F 2. The primary responsibility of the hospital as a whole is the proper care of the sick and injured.

T F 3. The medical record technician should become familiar with the fundamental principles of good organization.

T F 4. It will be of little value for the medical record technician to know the relationship existing between various functions in his department.

T F 5. Good management and good leadership are synonymous.

T F 6. The medical record librarian is generally considered to be on the second level of management.

T F 7. The more detail involved in planning and organizing the medical record department, the better job that the medical technician is apt to do.

T F 8. A chart of organization will insure good organization and management.

T F 9. When preparing a chart of organization, the first task is to list the main functions of the department.

T F 10. When an organizational chart is completed, it should be placed in the department for everyone to see.

T F 11. For a job analysis to be of full value, it must be used to evaluate the organizational aspects of each individual as well as the group as a whole.

T F 12. Before making a work flow study, you should inform the employees concerned.

T F 13. A straight-line flow of work is generally considered the best, but it is practically impossible for all work to flow in a straight line.

T F 14. Methods improvement may be defined as finding a better way to do a job.

T F 15. A work simplification program is intended to eliminate waste of time and materials with the procedure being confined to an examination of superfluous work rather than useful work.

T F 16. A procedure should be established for each job in the medical record department.

T F 17. A procedure manual is valuable as a statement of policies, as a guide to established methods of performaning a job, and as an important instructional tool.

T F 18. Policies should be the prerogative of the administration.

T F 19. The medical record technician may find that he will sometimes have the duty of outlining tentative policies for the operation of his department.

T F 20. Once a procedure manual has been made, you should constantly be on the alert for necessary revisions.

T F 21. A procedure manual should be kept up to date and is only applicable to the hospital for which it was made.

T F 22. Controls should be set up on the forms used in the medical records department.

T F 23. The purchasing department should not order medical record forms until they are notified that the forms are approved by the medical record committee.

T F 24. Small hospitals should make every effort to use standardize forms because the cost will be less.

T F 25. The medical record department should be placed where it will be of greatest convenience to the greatest number of physicians.

T F 26. If at all possible, the medical record department and the medical library should be adjacent.

T F 27. Little thought has been given to color in decorative schemes because it has little effect over motivation or efficiency of medical record personnel.

T F 28. A number of medical books should be available for reference work in every medical record department.

T F 29. The recommended arrangement of files that are to be stored in the file room is to place them on shelves.

T F 30. Wooden shelves are preferred over metal shelves for the file room.

T F 31. In hospitals where the records are seldom used, an open-shelf system of filing will be the most desirable.

T F 32. A private office for the medical record technician is a must when planning a medical record department.

T F 33. Mimeographing or personal stenographic services to physicians are generally considered to be the responsibility of the medical record department.

T F 34. Because of the heavy use and hard wear given to the summar sheet, it is recommended that this form be printed on 16-pound base.

T F 35. In selecting folders, you should give consideration to durability, a scored bottom, and a double edge.

T F 36. Budgets are forecasts of future expenses and are based on past spending experiences.

T F 37. Under no circumstances should the medical record librarian incur expenses which have not been approved in the final budget.

T F 38. Although the medical record librarian is usually asked to submit a report or two when the department is expanding to a new wing, he is neither qualified for nor likely to be a member of the planning team.

T F 39. Air-conditioning ducts should be covered with a soundproof dropped ceiling.

T F 40. Though a color should be stimulating, sunshine yellow is too bright for the walls of the filing area of the medical record department.

T F 41. Carpeting should be installed in the main medical record department because it will deaden machine noise and its over-all cost is about the same as tile.

T F 42. A secretarial pool incorporated into the medical repord department should be scattered throughout the department in strategic locations.

T F 43. The most efficient place to locate the file area is in the main section of the medical record department.

T F 44. Floor plans similar to the one illustrated in your text should be considered as models to be strived for when planning or remodeling a medical record department.

T F 45. Most hospitals in the United States do not have outpatient clinics.

T F 46. When buying medical record forms the quantity should be designated by the medical record librarian and the quality by the purchasing agent.

Completion

Directions: Fill in the blank(s) in each statement with the word(s) required to complete the sentence correctly.

1. The two basic elements of management and administration are ______________ and controlling, with organization being considered as the ______________ and management the ______________ and ______________ force to carry out the departmental functions.

2. The operations carried on by a department which are characteristic of that department are known as the ______________ of the department.

3. The method of providing leadership in group action is called ______________.

4. The power to act or command is called ________________ and flows ________________.

5. Accountability for the performance of an act or job is known as ________________ and flows ________________.

6. A description of the content and modifying factors of a job is known as a ________________ ________________

7. In making an analysis the ________________ jobs should be the first ones analyzed.

8. A determination of time required to regularly complete a given job is called a ________________ ________________ ________________ ________________.

9. The point between too much and too little has been defined as ________________.

10. A guide for the performance of specific jobs within the department is called a ________________ ________________.

11. A carefully formulated guide to action is called a ________________.

12. The budget is a device to ________________ expenditures and it must be ________________ so as to fit changing conditions.

13. The ratio of medical record librarians to discharges ________________ as the number of discharges increases.

14. The total number of medical record department personnel estimated for a hospital that has 200 beds and an annual discharge of 8,500 patients is ________________.

15. The number of medical record technicians estimated for a hospital that has 200 beds and an annual discharge of 8,500 patients is ________.

16. The determining factor in figuring the volume of work of a hospital is the number of ________________ ________________ ________________.

17. The medical record librarian should base his budget predictions on an analysis of previously made ________________ ________________ and work performance records.

18. The part of the total expense hospital budget devoted to salaries and wages is usually in excess of ________ per cent.

19. Budget reports are usually received ________________ to inform the medical record department how it is living up to its predictions.

20. The medical record department should be in a ______________ position based on a ______________ study which generally results in it being located in the ______________ section of the hospital.

21. Most office equipment companies have adopted soft shades of ______________, beige, and ______________ as standardized colors.

22. An excellent color for the ceilings of filing areas is a ______________ ______________ finish.

23. File rooms should have ______________ or ______________ ______________ on the floor.

24. Light fixtures should be choosen which supply an adequate amount of light and also provide for its proper ______________.

25. Minimum isle widths between vertical filing equipment should be ________ inches for inactive files and ________ inches for active files.

26. Usually sufficient space should be provided in the medical record department to file all the records of patients discharged during a period of ________ year(s) at the rate of ________ records per foot of filing shelf.

27. Medical record forms should be on good quality ________ by ________ ______________ paper and later trimmed to ________ x ________ inches for final filing.

Multiple-Choice

Directions: In the space at the left of each statement write the letter of the item which will provide the correct answer to complete the statement.

_____ 1. Authority originates at the top and flows functionally in a (A) line organization; (B) staff organization; (C) line and staff organization; (D) functionalized organization.

_____ 2. The medical record department is usually organized by (A) line; (B) staff; (C) line and staff; (D) functionalized organization.

_____ 3. For office work the average number of people that can be efficiently supervised by one person is usually considered to be about (A) three; (B) five; (C) seven; (D) nine.

_____ 4. The acutal preparation of the hospital budget is the responsibility of the (A) administration (B) governing board (C) medical record department; (D) business office.

_____ 5. When planning the medical record department, one should take into consideration possible expansion for the next (A) 5 years; (B) 10 years; (C) 15 years; (D) 20 years.

_____ 6. Generally, you should allow (A) 40; (B) 45; (C) 50; (D) 60 square feet per ordinary clerical worker when trying to figure space requirements for the medical record department.

_____ 7. Usually the best place to locate a file room is (A) over; (B) beside; (C) opposite; (D) under the medical record department.

Listing

Directions: List the items called for in each of the following. Select your answers carefully.

1. The types of organization commonly encountered are:

(A) ____________________ (C) ____________________

(B) ____________________ (D) ____________________

2. The medical records are kept readily available for:

(A) ____________________ (C) ____________________

(B) ____________________ (D) ____________________

3. A chart of organization can be a valuable aid in organizing and managing because it helps to:

(A) ____

(B) ____

(C) ____

(D) ____

(E) ____

4. Some of the hidden weaknesses that may be brought out by a chart of organization are:

(A) ____

(B) ____

(C) ____

(D) ____

(E) ____

5. Items which should appear on a job description are:

(A) ____________________ (F) ____________________

(B) ____________________ (G) ____________________

(C) ____________________ (H) ____________________

(D) ____________________ (I) ____________________

(E) ____________________

6. List the five main steps to follow when undertaking a work simplification program:

(A) ____

(B) ____

(C) ____

(D) ____

(E) ____

7. A policy should be:

(A) ____________________ (D) ____________________

(B) ____________________ (E) ____________________

(C) ____________________

8. The table of contents for a procedure manual should contain:

(A) ____________________ (D) ____________________

(B) ____________________ (E) ____________________

(C) ____________________

TRAINING PLAN AND PROGRESS RECORD
for
MEDICAL RECORD TECHNOLOGY

Employer's Copy

JOB TRAINING: What the Worker Should Be ABle To Do	Proficiency Shown	RELATED INFORMATION: What the Worker Should Know
	Basic Medical Records	
Check summary sheet, admission record, history record, physical examination records, laboratory records, physician's orders, graphic chart, and nurse's bedside record. Time in hours ___________	☒	Types and content of basic records, the origin of basic records, and typical errors of omission and commission that may occur.
	Special Medical Records	
Check consultation records, anesthesia records, report of operation, tissue report, x-ray report, obstetrical records, newborn records, and miscellaneous records. Time in hours ___________	☒	Rules and regulations pertaining to special records, the contents, types, and uses of special records.
	Medical Terminology	
Spell and pronounce medical terms correctly, follow directions in medical terms, and record in medical and surgical terms. Time in hours ___________	☒	Basic stems, prefixes, suffixes, singular and plural noun formations, homonyms, eponyms, common disease terms, anesthesiology terms used in medical records.
	Filing Medical Records	
File medical record, prevent misfiles, locate misfiles, file patient name cards, file physicians' index. Time in hours ___________	☒	Types of numbering systems, filing systems, files, rules for phonetic filing, cross-index filing.
	Indexing Records	
Cross-index diseases and operations, index diseases and operations, group index records. Time in hours ___________	☒	Methods of cross indexing, grouping by master code, topography, or international statistical classification number.

Statistical Data and Reports

Collect, prepare, and determine basic data for statistical reports, compile monthly and annual statistical reports, tabulate data for research, compute percentages and rates.

☒

Types of statistical reports, statistical classification of records, rates most frequently computed, methods of processing data.

Time in hours __________

Legal Aspects of Medical Records

Handle request for information, present medical record in court.

☒

Property right, privileged communication, procedure for releasing information,' hospital lien laws.

Time in hours __________

Interdepartmental Relations

Orient and instruct new employees, check work of others.

☒

Desirable personal qualities for successful contacts with people, responsibilities of various hospital departments.

Time in hours __________

Code for employer's use in marking student's progress

Performed some operations in area	☒	Performed some operations with reasonable proficiency	☒
Performed most operations in area	☒	Performed most operations satisfactorily	☒

TRAINING PLAN AND PROGRESS RECORD
for
MEDICAL RECORD TECHNOLOGY

Student's
Copy

JOB TRAINING: What the Worker Should Be ABle To Do	Proficiency Shown	RELATED INFORMATION: What the Worker Should Know
Basic Medical Records		
Check summary sheet, admission record, history record, physical examination records, laboratory records, physician's orders, graphic chart, and nurse's bedside record. Time in hours __________	☒	Types and content of basic records, the origin of basic records, and typical errors of omission and commission that may occur.
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Time in hours __________

Legal Aspects of Medical Records

Handle request for information, present medical record in court.	☒	Property right, privileged communication, procedure for releasing information,' hospital lien laws.

Time in hours __________

Interdepartmental Relations

Orient and instruct new employees, check work of others.	☒	Desirable personal qualities for successful contacts with people, responsibilities of various hospital departments.

Time in hours __________

Code for employer's use in marking student's progress

Performed some operations in area	☒	Performed some operations with reasonable proficiency	☒
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TRAINING PLAN AND PROGRESS RECORD
for
MEDICAL RECORD TECHNOLOGY

JOB TRAINING: What the Worker Should Be ABle To Do	Proficiency Shown	RELATED INFORMATION: What the Worker Should Know
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Code for employer's use in marking student's progress

Performed some operations in area	☒	Performed some operations with reasonable proficiency	☒
Performed most operations in area	☒	Performed most operations satisfactorily	☒